Journal

OF THE NATIONAL ASSOCIATION OF CHIROPODISTS

CONTENTS

	Page
Skin Diseases of the Lower Extremities of Interest to the Chiropodist — H. O. Perry, M.D.	155
An Orthopedic Method and Appliance Therapy — R. K. Bunch, D.S.C.	167
President's Message	172
Editorial—Pre-Professional Education and a Professional Life	173
Report of Vocational Guidance Committee	174
Health and Accident, Industrial and Workmen's Compensation Cases — F. Weinstein, D.S.C.	175
A Survey of Reciprocity Practices — L. A. Hansen, D.S.C.	182
Directory of Councils and Committees	185
Pharmaceutical Preparations for the Profession	187
Communications to the Profession	188
N.A.C. Wowen's Auxiliary	190
Executive Council Meeting	191
Organization News	191
Mood Elevators	200
Deaths Reported	201
Convention Dates	203

THE OFFICIAL PUBLICATION OF THE PROFESSION

VOL. 46, NO. 3 MARCH, 1956

DANGER AREAS DEMAND...

AN EXTRA MARGIN OF SAFETY

for you and your patient

Your hands contact dangerous areas of infection daily. Naturally you want the best protection available, both for yourself and your patient. Exhaustive tests have proved BACTINE on hands acts as a substantial barrier to bacteria. This anti-bacterial action persists for several hours in spite of recontamination. It remains active in the presence of water, blood, saliva or other secretions.

BACTINE also provides asepsis equivalent to that produced by a surgical scrub, in a minimum of time without irritating the skin... it is actually remedial to a number of skin irritations. Additionally, BACTINE destroys unpleasant odors. All we ask is that you try BACTINE and discover its advantages.

Bactine®

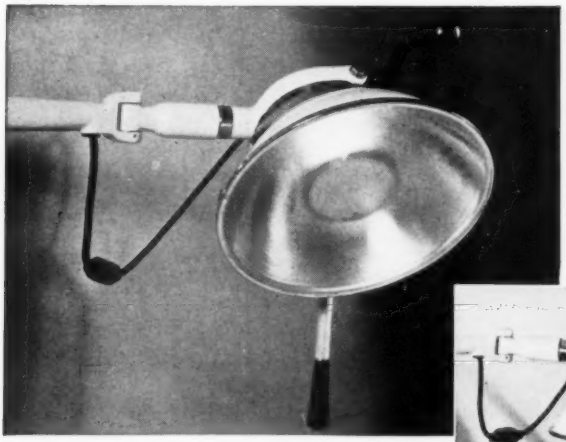
BRAND

GERMICIDE • FUNGICIDE • DEODORIZER

How available: Standard BACTINE . . . 1 gallon, 1 pint, and 6 ounce bottles. CONCENTRATED Bactine . . . pints only. You save money because a pint makes a gallon of standard BACTINE. Write DEPT. TC for BACTINE literature.

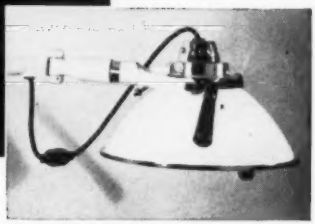
MILES LABORATORIES, INC.

ELKHART, INDIANA



Castle No. 26
Chiropodist Light with new "any-angle" lamp-head—for easier work

swing it sidewise . . .



turn it up or down . . .

New light turns everywhere

. . . to make your work easier

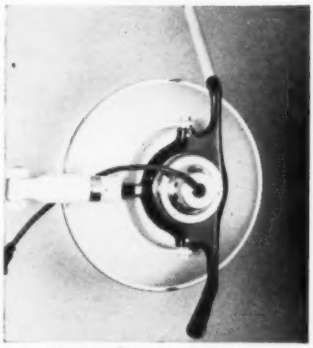
No more *wishing* you could get better light from *all* angles of your work area—now you have it!

You'll like the easy way Castle's new lamp turns to the right, left, sidewise, around, up and down . . . to *any position imaginable!*

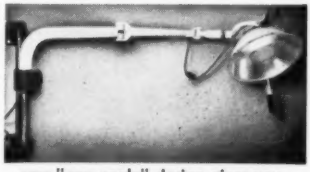
Adjustment is easy because lamphead turns through 350°. And you get added positions of the lamp from the newly added 2-jointed link.

This "any-angle" light is color-corrected for quick seeing and sure diagnosis. It illuminates a large field with just the right intensity. It has that glareless quality which reduces eyestrain and fatigue.

See how this light will work in your office—phone the Castle dealer for a demonstration. Don't wait. The sooner you call, the sooner you can have the benefits of this new light.



turn it around . . .



new "any-angle" design gives you complete flexibility in Castle's No. 26 Light

Castle LIGHTS AND STERILIZERS
WILMOT CASTLE COMPANY : 1869 E. HENRIETTA RD. : ROCHESTER, N. Y.

THE JOURNAL
OF THE
NATIONAL ASSOCIATION OF CHIROPODISTS
3301 16th Street, N.W., Washington 10, D. C.
DUpont 7-2029
A. Rubin, D.S.C., Editor

EXECUTIVE COUNCIL

Dr. Ralph E. Fowler, *President*
5050 Joy Road, Detroit, Mich.

Dr. Felton O. Gamble, *President Elect*
1888 N. Country Club Road, Tucson, Ariz.

Dr. Jonas C. Morris, *Vice President*
108 W. Merchant Street, Audubon, N. J.

Dr. George E. Guenzler, *Vice President*
302 Smith Building, Freeport, Ill.

Dr. Walter C. Gigerich, *Retiring President*
Arkansas National Bank Building, Hot Springs, Ark.

Dr. Morse K. Upshaw
511-13 Lamar Life Bldg., Jackson, Miss.

Dr. Raymond K. Locke
134 Engle Street, Englewood, N. J.

Dr. James A. Conforti
767 Broadway, Bedford, Ohio

Dr. Alec C. Levin
1835 Eye St., N.W., Washington, D. C.

Dr. Harry I. Horowitz
30-96 Steinway St., Astoria, L. I., N. Y.

Dr. E. P. Erickson
706-08 Mohawk Bldg., Spokane, Wash.

A. Rubin, D.S.C., *Secretary*

All expressions of opinion and all other statements are published on the authority of the writer over whose signature they appear, and are not to be regarded as expressing the views of the National Association of Chiropodists, unless such statements or opinions have been adopted by the Association.

Deadline for *Journal* copy is the 10th of the month before publication (example: copy for June issue should be in our hands by May 10th). The *Journal* is usually mailed between the 10th and 15th of the month noted on the issue (the June issue is mailed between the 10th and 15th of June).

Manuscripts must be typewritten, double spaced, and an original copy must be submitted. References should give name and initials of author, volume, page, month and year of publication in the case of periodicals, and publisher and place and year of publication in the case of books. Illustrations must be clear photographs. Glossy prints are preferred. Drawings must be made in black ink on heavy paper or cardboard. Any illustrations should bear the author's name and be numbered in the order in which they are referred to in the text. Illustrations must not be pasted on the manuscript. Legends should be placed on a separate sheet. Tables are not illustrations and should be numbered separately.

Articles are accepted with the understanding that they have not been published previously and that they are submitted solely to *The Journal*. Orders for reprints must be placed at the time manuscripts are submitted.

Communications regarding manuscripts, news items, advertising, editorial and business matters should be addressed to the Editor. Advertising and editorial copy must conform to the official standards established by the Association.

Subscription is included in the annual membership dues of the National Asosciation of Chiropodists. The subscription rate for non-members is $10.00 a year in advance. Single copies $1.00 each. Remittance should be made payable to the National Association of Chiropodists.

Notice of change of address should be received six weeks before the change is to become effective. Old and new address must be given.

The *Journal of the National Association of Chiropodists* is published monthly and copyrighted in 1956, by the National Association of Chiropodists.

Entered as second class matter at the P. O. at Boston, Mass., March 27, 1934, under the act of March 3, 1879. Publication office, 375 Broadway, Boston, and Editorial-Executive offices 3301 16th St., N.W., Washington 10, D. C.

Why Torture Tender Skin?

when soap irritates

LOWILA® cake

cleanses tender skin gently . . . *without irritation*

Indications:
"tender" skin • "dermatitic" skin • "allergic" skin

Try LOWILA yourself, Doctor!
Send for a FULL SIZE cake today

LA-10

Westwood PHARMACEUTICALS
DIVISION OF FOSTER-MILBURN CO.
468 DEWITT ST. • BUFFALO 13, N. Y.

AFFILIATED STATE SOCIETIES

Showing Society, President and Secretary

Alabama Association of Chiropodists	Dr. John Cooper, 407 Empire Bldg., Birmingham, Ala. Dr. Elizabeth P. Sealy, 34 S. Perry St., Montgomery, Ala.
Arizona Chiropody Association	Dr. Samuel Mason, 144 N. 1st St., Phoenix, Ariz. Dr. Martin Snyder, 2629 E. Broadway, Tucson, Ariz.
Arkansas Association of Chiropodists	Dr. W. F. Walker, 912 E. Main, El Dorado, Ark. Dr. Walter C. Gigerich, Arkansas Natl. Bank Bldg., Hot Springs, Ark.
California Association of Chiropodists, Inc.	Dr. Robert Shor, 4480 Crenshaw Blvd., Los Angeles, Calif. Mr. E. A. Devereux (Ex. Sec.), 3401 Riverside Blvd., Sacramento, Calif.
Colorado Association of Chiropodists	Dr. G. D. Patton, 1013 9th Ave., Greeley, Colo. Mrs. L. I. Lorett (Ex. Sec.), 4871 S. Penn, Englewood, Colo.
Connecticut Chiropody Society Inc.	Dr. S. Rudnick, 267 Center St., West Haven, Conn. Dr. Margaret L. Halloran, 75 Pratt St., Hartford, Conn.
Delaware, Chiropody Society of	Dr. Lawrence Silverman, 2310 Market St., Wilmington, Del. Dr. Harold W. Orr, 2210 Baynard Blvd., Wilmington, Del.
District of Columbia Podiatry Society	Dr. Alec Levin, 1835 Eye St., N. W., Washington, D. C. Dr. Morris L. Selby, 419 Colorado Bldg., Washington, D. C.
Florida, Chiropody Association of	Dr. R. L. Dryfuse, 518 Lake Ave., Lake Worth, Fla. Dr. Joy E. Adams, 401 Fla. Natl. Bank Bldg., St. Petersburg, Fla.
Georgia Association of Chiropodists	Dr. J. B. Stevens, 420 Bibb Bldg., Macon, Ga. Dr. William J. Meadors, 306 Martin Bldg., Columbus, Ga.
Idaho Association of Chiropodists	Dr. J. E. Franden, 719 Main St., Boise, Idaho Dr. M. D. Harris, 341 W. Clark. Pocatello, Idaho
Illinois Chiropody Society	Dr. J. B. Collet, 1482 Miner St., Des Plaines, Ill. Dr. Max L. Golde, 2104 Broadway, Rockford, Ill.
Indiana State Podiatrists Association	Dr. C. W. Hoard, 406 W. Jefferson St., Fort Wayne, Ind. Dr. A. J. Deeley, 413 Gettle Bldg., Fort Wayne, Ind.
Iowa State Chiropody Association	Dr. R. R. Carnes, Granby Bldg., Cedar Rapids, Iowa Grace C. Alber (Ex. Sec.), 638 37th St., Des Moines, Iowa
Kansas State Chiropody Association	Dr. Lawrence Krause, 1107 Williams St., Great Bend, Kansas Dr. Jacquoline Comstock, 527 Mills Bldg., Topeka, Kansas
Kentucky Association of Chiropodists	Dr. Stanley Stivers, 1409 Broadway, Paducah, Ky. Chester A. Nava, 728 Starks Bldg., Louisville, Ky.
Louisiana State Chiropodists' Association	Dr. Nicholas Zichichi, 1016 Pere Marquette Bldg., New Orleans, La. Dr. Joseph Weinberg, 5300 Freret St., New Orleans, La.
Maine, Chiropody Society of	Dr. D. J. Desjardin, 14 Lisbon St., Lewiston, Maine Dr. Gerald Rosen, 132 Main St., Biddeford, Maine
Maryland Pedic Association Inc.	Dr. V. S. Cantrell, 310 S. Division St., Salisbury, Md. Dr. M. D. Fielding, 7942 Wisconsin Ave., Bethesda, Md.
Massachusetts Chiropody Association	Dr. Francis B. Powers, 19 Dale Ave., Gloucester, Mass. Dr. Sidney G. Holmes, 206 Huntington Ave., Boston, Mass.
Michigan Chiropody Association	Dr. B. C. Stein, 9621 Jos. Campau, Hamtramck, Mich. Mr. J. R. Dawson (Ex. Sec.), 19 N. Washington, Ypsilanti, Mich.
Minnesota Association of Chiropodists	Dr. Rolan Froyd, 405 Physicians & Surgeons Bldg., Minneapolis, Minn. Dr. Richard E. Rice, 2014 Emerson Ave., No., Minneapolis, Minn.
Mississippi Society of Chiropodists, Inc.	Dr. Wm. P. Fitzgerald, 2613 8th St., Meridian, Miss. Dr. M. K. Upshaw, Jr., 511-13 Lamar Life Bldg., Jackson, Miss.
Missouri Association of Chiropodists	Dr. Robert Triplett, 121 S. Main St., Nevada, Mo. Dr. C. B. Footlick, 520-22, 12th & Walnut Bldg., Kansas City, Mo.
Montana Association of Chiropodists	Dr. D. C. Scott, 315 Barber-Lydiard Bldg., Great Falls, Mont. Dr. L. M. Jennings, Rm. 1, Lovelace Bldg., Bozeman, Mont.
Nebraska Association of Chiropodists	Dr. K. C. Nielsen, 640 City Natl. Bank Bldg., Omaha. Nebr. Dr. G. F. Heroman, 231 City Natl. Bank Bldg., Omaha, Nebr.
Nevada Association of Chiropodists	Dr. B. E. Edwards, Medico Dental Bldg., Reno, Nevada Dr. William A. Edwards, 150 Chestnut St., Reno, Nevada
New Hampshire Chiropody Association	Dr. Robert Cingolani, 3 Pleasant St., Concord, N. H. Dr. Tomy A. Levingston, 39 Pleasant St., Portsmouth, N. H.
New Jersey Chiropodists' Society	Dr. Milton E. Ashur, 681 Bergen Ave., Jersey City, N. J. Dr. Jack Horwitz, 463 High St., Burlington, N. J.
New Mexico Association of Chiropodists	Dr. Milton Goodman, 406 North Penn, Roswell, N. Mexico Dr. I. Michael Gross, 205-A Truman, N.E., Albuquerque, N. Mex

KNOCKOUT FOR PAIN!

When muscles ache at the end of a tiring day, MINIT-RUB® will give quick relief. A brisk application of this modern counterirritant is followed promptly by a soothing feeling of mild warmth. Muscles relax and pain is relieved.

BRISTOL-MYERS CO.
19 West 50 St., New York 20, N.Y.

New York, The Podiatry Society of the State of	Dr. Milton Wolfson, 5 E. 9th St., New York, N. Y. Mr. G. Hollander (Ex. Sec.), 353 W. 57th St., New York, N. Y.
North Carolina Chiropodists' Association	Dr. Paul Lyon, 110 Coast Line St., Rocky Mount, No. Car.
North Dakota Association of Chiropodists	Dr. D. J. Cameron, 401-402 Murchison Bldg., Wilmington, N. C.
Ohio Chiropodists Association	Dr. R. F. Peterson, 14½ S. Third St., Grand Forks, No. Dak. Dr. E. B. Snuff, 611 1st Ave. No., Fargo, No. Dak.
Oklahoma Chiropody Association	Dr. Sam Korman, 1229 Edison Bldg., Toledo, Ohio Mr. J. E. Farmer (Ex. Sec.), 30 E. Broad St., Columbus, Ohio
Oregon State Association of Chiropodists	Dr. H. R. Johnson, 401 N. Beard St., Shawnee, Okla. Dr. Robert H. James, 113 S. Peters, Norman, Okla.
Pennsylvania, Chiropody Society of	Dr. W. R. Schiess, 209 E. Third St., The Dalles, Oregon Dr. George McCauley, 1700 N.E. 41st St., Portland, Oregon
Rhode Island Chiropodists' Society	Dr. Charles D. Bossart, 822 Washington Rd., Pittsburgh, Pa. Dr. Arnold W. Newman, 5411 Chester Ave., Philadelphia, Pa.
South Carolina Chiropody Association	Dr. W. P. Proulx, 8 St. John St., West Warwick, R. I. Dr. Samuel Kouffman, 290 Westminster St., Providence, R. I.
South Dakota Association of Chiropodists	Dr. Philip Cogen, 4 W. Court St., Greenville, So. Car. Dr. H. A. McAninch, 221 E. Main St., Spartanburg, So. Car.
Tennessee Chiropody Association	Dr. E. I. Shindler, 222½ W. Third, Yankton, So. Dak. Dr. E. A. Laga, 303 Medical Arts Bldg., Watertown, So. Dak.
Texas, Chiropody Society of	Dr. Ralph E. Meece, 707 High St., Columbia, Tenn. Dr. Stephen A. Lamm, 3355 Poplar Ave., Memphis, Tenn.
Utah State Association of Chiropodists	Dr. K. L. Rice, 606 Mills Bldg., El Paso, Texas Dr. B. M. Sanders, 302 Peoples National Bank Bldg., Tyler, Texas
Vermont Chiropody Association	Dr. L. C. Larsen, 701 Medical Arts Bldg., Salt Lake City, Utah. Dr. Paul W. Smith, 316 Darling Bldg., Salt Lake City, Utah
Virginia Association of Chiropodists	Dr. R. M. Coburn, South Main St., White River Junction, Vt. Dr. Regis P. Nolin, 14 Clarke St., Burlington, Vt.
Washington State Chiropody Association	Dr. M. D. Cummins, 1001 W. Franklin St., Richmond, Va. Dr. Irwin T. Domsky, 2780 S. Randolph St., Arlington, Va.
West Virginia, Chiropody Society of	Dr. F. L. Peck, 308 Security Bldg., Olympia, Wash. Dr. E. P. Erickson, 706-8 Mohawk Bldg., Spokane, Wash.
Wisconsin Society of Chiropodists	Dr. J. J. Bates, 1501 West Virginia Bldg., Huntington, W. Va. Dr. Malcolm P. Iams, 519 Union Trust Bldg., Parkersburg, W. Va.
Wyoming Association of Chiropodists	Dr. Ralph R. Wichgers, 2218 N. Third St., Milwaukee, Wis. Dr. E. M. Hatfield, 270 W. Broadway, Waukesha, Wis.
	Dr. Herbert C. Fair, 100 21st St., Cheyenne, Wyo. Dr. Duane NeuSchultz, 136 W. 22nd Ave., Torrington, Wyo.

Affiliated Organizations

N.A.C. Women's Auxiliary—Mrs. Miriam Shor, 4480 Crenshaw Blvd., Los Angeles, Calif.

Military Association of Chiropodists—Dr. C. R. Brantingham, 311 Security Bldg., Long Beach, Calif.

American College of Foot Surgeons—Dr. J. M. Kohl, 3959 N. Lincoln Ave., Chicago, Ill.

American Society of Chiropodical Roentgenology—Dr. D. C. Rasmussen, City National Bank Bldg., Danbury, Conn.

Chiropody Bibliographical Research Society—Dr. S. E. Reed, 425 Kresge Bldg., Des Moines, Iowa.

American College of Foot Orthopedists—Dr. P. R. Brachman, 25 E. Washington St., Chicago, Ill.

American Association of Hospital Chiropodists—Dr. J. W. Carby, 12th & Walnut Bldg., Kansas City, Mo.

National Association of Chiropody Students—G. W. Anderson, 4347 Gage Ave., Lyons, Illinois.

Non-Affiliated

The Federation of Chiropody Boards—Dr. L. A. Hansen, 800 Professional Bldg., Kansas City, Mo.

REGION THREE

N.A.C. CHIROPODY SCIENCE CONCLAVE

"The World's Outstanding Annual Post-graduate Chiropody Conference"

Delaware, Maryland, New Jersey and Pennsylvania

APRIL 12, 13, 14 and 15, 1956

THE AMBASSADOR, ATLANTIC CITY, N. J.

Program of Scientific Features

CHARLES R. TURCHIN, D.S.C., Washington, D. C.—
"PRACTICAL BALANCE THERAPY"

Abstract: In a full day post-graduate seminar, a master of his subject will conduct, without assistants, a comprehensive solo presentation including: Expert analysis of the theories and principles of Balance Therapy; evaluation of relative facts established by professional experience and scientific research; exposition of indications and contraindications for use; practical demonstrations of the most simplified and effective methods of Balance Therapy application.

MAX POMERANTZ, M.D., Cleveland, Ohio—
"ANKLE EDEMA"

Abstract: Illustrated presentation of: Differential diagnostic features; local and systemic etiologic factors and considerations: detailed specific treatments for this common but frequently difficult chiropodical problem.

ROBERT D. NICKLAS, D.S.C., Pittsburgh, Pa.—
"THERAPEUTIC MASSAGE AND MANIPULATION"

Abstract: An illustrated lecture and demonstration depicting the rationale, indications, contraindications and anticipated results of this important but oft neglected modality.

"VERRUCA THERAPY SYMPOSIUM"

SAMUEL BREZAK, Pod.D., Brooklyn, N. Y.
Presenting Chemical Treatment Methods

JAMES F. BATES, D.S.C., Philadelphia, Pa.
Presenting Desiccation, Coagulation, Galvanic Currents and Dry-Ice Treatment Methods

LOUIS M. NEWMAN, D.S.C., Philadelphia, Pa.
Presenting Ambulatory Surgical Treatment Methods Including Sclerotherapy, Curettage and the new SURGICAL PLANING.

Abstract: Each of the panelists will explain the advantages and disadvantages of each respective method and will report the results of long experience.

(Continued on next page)

REGION THREE

N.A.C. CHIROPODY SCIENCE CONCLAVE

"The World's Outstanding Annual Post-graduate Chiropody Conference"

(Continued)

"CONTEMPORARY PRACTICE MANAGEMENT"

Abstract: Three separate panel discussions in consideration of various phases of chiropody that are pertinent to successful practice management. Each panel is directly pointed to a definite stage in practice growth and features outstanding authorities at their respective practice levels.

Panelists

Under 6 years in practice:—DR. A. C. STRUBLE, JR., Elwood City, Pa.; DR. GEORGE W. DOLINGER, Dunmore, Pa.; DR. ANTHONY SABATELLI, Carbondale, Pa. Moderator—DR. BERNARD C. EGERTER, Pittsburgh, Pa.

From 6 to 10 years (inclusive) in practice:—DR. JOSEPH D. FLETCHER, New Castle, Pa.; DR. WILLIAM ZIEGLER, JR., Philadelphia, Pa.; DR. JOHN R. REYER, Sharon, Pa. Moderator—DR. JONAS C. MORRIS, Audubon, N. J.

Over 10 years in practice:—DR. H. L. COLLINS, Columbus, Ohio; DR. LEONARD HYMES, Pleasantville, N. J.; DR. JOHN PANKRATZ, Meadville, Pa. Moderator—DR. H. HARVEY HABER, Pittsburgh, Pa.

FRANK P. BIGLEY, Color Engineer, Philadelphia, Pa.— "COLOR DYNAMICS"

Abstract: Presentation of findings of long research to determine the physical and psychological effects of color. The scientific application of color in offices, equipment and furnishings for eye ease and the uplift of patient morale utilized in combination with sound principles of attractive interior decor.

JUSTIN L. POWERS, B.S., Ph.D., Washington, D. C.— "THE NATIONAL FORMULARY— ITS VALUE TO THE CHIROPODIST"

Abstract: The evaluation of this "Pharmaceutical Treasury" as an important aid to the chiropodist in selecting proper drugs and medications and to the enhancement of the profession's prestige by the inclusion of a chiropody listing.

HARRY L. HOFFMAN, Ph.G., D.S.C., Washington, D. C.— "WHY PRESCRIBE?"

Abstract: Discourse on the contribution of prescription writing to increased respect and prestige of chiropody among the public, inter-professionally and among the large drug and chemical manufacturers. Service of "Rx-ing" as record and proof of proper professional treatment.

SEWARD P. NYMAN, D.S.C., Washington, D. C.—
"PHENOL-ALCOHOL TECHNIQUE FOR NAIL CORRECTION"

Abstract: Color motion pictures and slides presentation illustrating immediate office technique for correction or permanent removal of inverted or ingrown nails. This painless office procedure requires no post-operative sedation.

AARON EISENBERG, C.P.A., Newark, N. J.—
"INCOME TAX PROBLEMS OF THE CHIROPODIST"

Abstract: Tax knowledge and advance planning can result in real tax savings. Basic rules for professional incomes and deductions will be discussed. How to prove deductions for business entertainment; home and office expenses; allowable deductions to maintain your practice; records required to support and substantiate tax deductions; billings proceedings; gain or loss from sale of practice; depreciation deductions and general "do's" and "don'ts" of income tax accounting.

ULTRASONIC THERAPY FORUM:

Edward Schwartzenfeld, D.S.C., University Heights, Ohio
Samuel Brezak, Pod.D., Brooklyn, N. Y.
Robert A. Doman, M.D., Drexel Hill, Pa.

Abstract: Commercial technical knowledge, laboratory experiment and practical professional experience will be tapped to evolve a sound evaluation of this new modality as a therapeutic measure.

GILBERT MASTER, D.S.C., Philadelphia, Pa.—
"REMEDIAL EXERCISES"

Abstract: Illustrated instruction demonstrating therapeutic exercises for improvement of local muscle function. Indication for such exercises and method of teaching patients the proper performance thereof.

JONAS C. MORRIS, D.S.C., Audubon, N. J.—
Vice President of the N.A.C.
ABE RUBIN, D.S.C., Washington, D. C.—
Editor, Journal of the N.A.C.
"THE N.A.C. AT WORK"

Abstract: Eminent officers, long experienced in the affairs of the N.A.C., will describe and explain the policies, planning, problems and accomplishments of our National organization and answer relative inquiries.

NON-PAREIL SOCIAL AND WOMEN'S PROGRAMS

Registration $10.00
Make check or money order payable to
Region 3. N.A.C. and mail to

Dr. Joseph M. Funston, 205-B North Wilson Ave., Margate, N. J.

"Cradle Cup" Construction Permits Maximum Inlay Build-Up

Chiropodists know the great importance of shoes that permit *maximum inlay build-up* when a child's feet need special care.

Selby Junior Arch Preserver Shoes with "Cradle Cup" construction are built for maximum inlay build-up. Long right and left inside counters follow the contour of the last and extend beyond the arch for *extra support*. It also affords the wedge Thomas heel extending forward under the arch to provide an additional heel base for adding *extra inlays* and stronger under footing.

The excellence of Selby Junior Arch Preservers is the result of the knowledge and skill acquired in more than three quarters of a century of fine shoemaking.

When you recommend shoes for children, remember—Selby Juniors are the only *genuine* Arch Preserver Shoes for children.

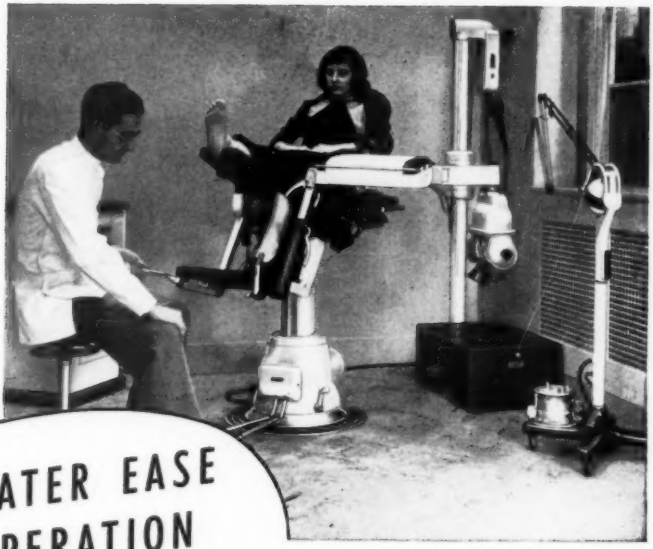
The only genuine Arch Preserver Shoes for children

• *If Selby Junior Arch Preservers are not available in your city, please write directly to us.*

The Selby Shoe Company
Portsmouth, Ohio

Selby
JUNIOR ARCH PRESERVER
Shoes

MORE THAN THREE QUARTERS OF A CENTURY OF FINE SHOEMAKING



GREATER EASE
of OPERATION

with Ritter
CHIROPODY EQUIPMENT

● Each piece of modern Ritter chiropody equipment has been designed to save you time . . . allows you to operate in a natural relaxed position. The Ritter Chiropody Chair is adjusted quickly and easily. The patient is brought to your operating level quietly and smoothly by this motor-driven chair. A Ritter Model "E-3" Sterilizer takes care of your sterilizing problems automatically. A Ritter Stool helps you relax while attending your patients. With a Ritter Chiropody X-ray you can take radiographs with a minimum of time and effort.

Visit your chiropody dealer and see the many time and energy-saving advantages of modern Ritter Chiropody equipment.

Ritter Company Inc.

4015 RITTER PARK • ROCHESTER 3, NEW YORK

* *Foul weather is fair weather for athlete's foot infections!*

YOU CAN DEPEND ON

OCTOFEN®

TO KNOCK OUT

ATHLETE'S FOOT FAST

OCTOFEN is becoming an increasing favorite in the treatment of athlete's foot because of its successful action in treatment of certain fungus infections. OCTOFEN LIQUID containing fungicidal 8-hydroxyquinoline kills T. mentagrophytes within two minutes by laboratory tests. Early cases never get a foothold; advanced cases often respond to treatment in as little as two weeks time. Clinical studies reveal that OCTOFEN LIQUID is effective in more than 90% of all cases treated, and is kind to tender, infected skin. It is greaseless, non-staining and quick drying. No awkward wet dressings or packs are required – just swab the affected parts generously when the patient is under treatment and instruct continuation at home until relieved.

WE RECOGNIZE CHIROPODISTS AND PODIATRISTS AS FOOT HEALTH AUTHORITIES

There's
structio
It kills
commo
labora
8-hydro
but ge
dorma

McKess

OCTOFEN POWDER

Used primarily as a superb preventive measure . . . and between liquid applications . . . patients should be instructed to shake liberally in hose and shoes. Assures fungistatic action, in a satin-smooth, non-caking form. Helps keep feet extra-dry, thanks to thirsty silica gel. Soothing to tired, tender feet and a splendid protection against foot odors.

OCTOFEN LIQUID

There's no over-treatment, no skin destruction, with OCTOFEN LIQUID. It kills T. mentagrophytes, the most common culprit in two minutes flat in laboratory tests. Its active agent 8-hydroxyquinoline benzoate is potent but gentle. It penetrates deep to kill dormant fungi, dries fast!

Free Sample! WRITE TODAY!

McKesson & Robbins, Inc.
Bridgeport 9, Conn. Dept. J N C

Kindly send me free samples of your Octofen Liquid and Octofen Powder.

NAME_____

ADDRESS_____

CITY_____ ZONE____ STATE_____

McKesson & Robbins, Inc., Bridgeport 9, Conn.

For Prophylaxis and Treatment of

FUNGOUS INFECTIONS
OF THE FEET

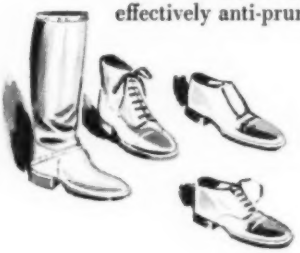
TINEA PEDIS
(Athlete's Foot)

USE

Desenex®

OINTMENT AND POWDER ZINCUNDECATE
SOLUTION OF UNDECYLENIC ACID

The unique "Undecylenic Acid–Zinc Undecylenate Team" available in DESENEX gives unsurpassed protection against the onset of acute *Tinea* Pedis (Athlete's Foot). *Cures the average moderate to severe case in two to three weeks.* In addition, DESENEX POWDER is effectively anti-pruritic, drying and astringent.



Outstandingly
ANTI-MYCOTIC
ANTI-PRURITIC
NOTABLY NON-IRRITATING
PLEASANTLY SCENTED

Available at all pharmacies.
Samples and literature sent on request.

Maltbie
MALTBIE LABORATORIES DIVISION
WALLACE & TIERNAN INC.
25 MAIN ST BELLEVILLE 9, NEW JERSEY, U S A

PD-52

IN MY JOB I KNOW ABOUT HEAT RASH

...I USE SOOTHING, MEDICATED **AMMENS®**

Especially whenever tender skin is irritated by heat, moisture or chafing, AMMENS Powder gives a prompt feeling of soothing comfort.

AMMENS' starch granules, evenly dispersed in talc, provide an absorbent coating on irritated skin. Oxyquinolin and zinc oxide, blended in the powder, help protect macerated crevices against bacterial invasion.

For skin comfort—especially following strenuous work or play, or in hot weather—keep a can of AMMENS close at hand.

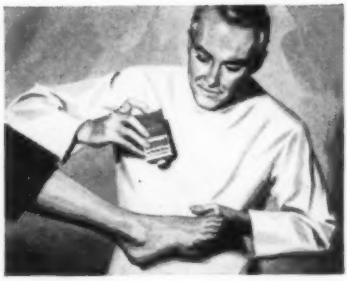
BRISTOL-MYERS COMPANY

19 West 50 Street, New York 20, New York

Distributor for Charles Ammen Co., Alexandria, Louisiana

Latest research proves*

Dry fungicidal powder helps prevent athletes foot



Scientific findings confirm greater effective value of powder

Newest experiments endorse powder as an effective guard against Athletes Foot. Researchers report regular use of a drying, mildly fungus-killing powder prevents dermatophytosis. The findings support the popularity of prevention of fungus infection by powder with both doctors and patients.

Many doctors use and recommend Quinsana Powder. Quinsana covers the skin with a powder-barrier that blocks the growth of Athletes Foot fungi. Moist, fungi-breeding cracks in sensitive areas around the toes disappear. Quinsana soothes and cools hot, tired feet while it protects them. Use and recommend Quinsana!

**Experiments conducted under Army grant of Doctors from New York University Post Graduate Medical School and the Skin and Cancer unit of University Hospital.*

Mennen . . . *Skin Specialist for over 80 years*

THE
JOURNAL
OF THE
NATIONAL ASSOCIATION of CHIROPODISTS
THE OFFICIAL PUBLICATION OF THE PROFESSION

VOLUME 46 MARCH, 1956 NUMBER 3

SKIN DISEASES OF THE LOWER EXTREMITIES OF INTEREST TO CHIROPODISTS*

HAROLD O. PERRY, M.D.†
Rochester, Minn.

THE field of dermatology encompasses the study of all diseases that involve the skin. Within the specialty, then, attention is paid not only to local diseases originating in situ, but also to skin lesions as they occur as manifestations of internal disorders. The dermatologist thus finds he is often co-operating with other medical specialists—the pediatrician, the internist and the surgeon—so that the combined efforts of all work for the benefit of the patient.

There is likewise an overlapping interest between the fields of chiropody and dermatology. The purpose of this presentation is to discuss diseases of mutual interest to the chiropodist and dermatologist. The dermatologist's handling of the more common problems of the feet may prove of interest because of the different therapeutic approach. In each of the diseases less frequently seen, an effort will be made to delineate its main features as it occurs on the feet or legs, followed by a discussion of other features of the disorder as it occurs elsewhere on the body. By this method it is hoped to emphasize the importance of at least a cursory examination of the readily visible skin areas other than the feet, in elucidating unusual skin conditions as they occur on the lower extremities.

Hyperhidrosis and Bromidrosis

Among the most common foot complaints are those of "sweaty and smelly feet." The associated effects of hyperhidrosis and bromidrosis, rather than any morphologic changes in the skin of the feet, bring patients with these disorders to the doctor. The patient with hyperhidrosis complains of difficulty in maintaining good foot hygiene. The feet are continually wet, the stockings soaked with perspiration and the shoes sodden. Patients with bromidrosis, in addition, complain of the fetid odor of the feet. Only the occasional patient complains of tenderness of the feet under these conditions. Fre-

*Read at the meeting of Region Six of the National Association of Chiropodists, Rochester, Minn., April 4, 1955.
†Section of Dermatology, Mayo Clinic.

quent washing of the feet and the changing of stockings and shoes do much to alleviate these complaints, but oftentimes these measures, however conscientiously performed, afford inadequate relief.

Help is obtained from the use of antiperspirants, either in liquid or ointment form, applied to the cleansed feet nightly for a week, and then every other night thereafter. The active ingredient of many of these products is aluminum chloride, or a closely related compound, which may be prescribed in a 15 per cent aqueous solution if one wishes to avoid a proprietary product. It seems essential that these preparations be applied at a time when the feet are not perspiring, so that the medicaments have an opportunity to act before being washed away.

The systemic approach to this problem by drugs that act through the autonomic nervous system are of benefit to some patients but unsatisfactory for routine use. Not only is sweat control inadequate, but the associated side effects are undesirable. Chemical sympathectomy has recently been reported in patients with severe hyperhidrosis[1]. The procedure is a rather formidable one, however, and requires the services of a consultant who is specialized in these skills. Roentgen therapy in dosage sufficient to cause cessation of sweating produces an actinodermatitis, and, for this reason, is contraindicated.

Dermatitis Venenata

When a patient presents a dermatitis of the feet that mirrors the configuration of the shoes, no difficulty is encountered diagnosing dermatitis venenata (contact dermatitis). This problem of contact dermatitis from footwear has been studied by Gaul and Underwood[2], who found that in shoe manufacturing numerous substances were used to which the wearer could become sensitive. Shatin and Reisch[3], however, have expressed the view that the accelerators and antioxidants in the various rubber products incorporated in shoe fabrication are the most important of the many possible sensitizers present. The dermatitis may consist only of erythema, or it may be more severe and include blistering, weeping, scaling and crusting. If it can be determined by patch testing that some portion of the lining or padding of the shoe is the offending part, substitution of another material for this prevents future trouble. It may be necessary to substitute shoes that contain no rubber products and therefore no antioxidants or accelerators, in order to keep the patient free of recurrences. The immediate treatment of the dermatitis consists of soothing wet dressings and ointments.

Tinea Pedis

A definite diagnosis of fungous infection of the feet should be made only when the diagnosis is substantiated either by microscopy or by culture. A small fragment of skin macerated in a 10 per cent solution of potassium hydroxide will make mycelial fragments of the fungus easily visible under the low-power objective of the microscope. An immediate positive diagnosis is achieved by this technic. Culturing skin specimens requires 2 to 3 weeks for growth adequate to permit identification of the causative mycotic organisms. The cultural method affords species identification of the pathogen, whereas the microscopic method indicates only that a fungus is present.

Fungous infections of the feet can temporarily disable a patient, although at times an existing tinea

pedis is entirely asymptomatic. Under conditions of increased heat and moisture, the process may flare, at which time intense pruritus, pain and discomfort are experienced by the patient. The fact that women are less affected with this disease than men may be related to the shoe styles currently in vogue, which adequately aerate the feet, keeping them dry and cool. Women habitually wear thin stockings, so that evaporation of perspiration is easily achieved. Men, on the other hand, tend to wear shoes which tightly enclose the feet and prevent ventilation. Heavy woolen socks are worn, frequently even on warm days, increasing local heat and stimulating perspiration of the feet. The feet become encased in a veritable steam bath. Because synthetic materials, now popular in sock manufacturing, are essentially nonabsorbent, added perspiration is maintained in contact with the feet.

Two clinical types of infection are seen. The first is an acute eczematoid reaction with blistering, crusting and scaling, which indicates the onset of an acute infection or flare of a more chronic one. Treatment of this type consists of the use of wet dressings; a solution of potassium permanganate, 1:16,000, or 0.5 per cent solution of aluminum subacetate is satisfactory. The second, or chronic, type of tinea pedis consists of thickening, dryness and scaling of the skin. The aim of treatment, in this form, which seems to be less amenable to cure, is to avoid acute flares of the process. Unsaturated fatty acids applied to the feet at night in ointment form and during the day in powder form give the necessary control. Attention to foot hygiene is necessary to control exacerbations of an existing tinea pedis. Frequent changing of shoes and socks and swabbing the feet dry with alcohol after bathing do much to ensure that the feet are kept dry, thereby discouraging growth of the fungus.

Callosities

Callosities are circumscribed, horny plaques of epidermis that vary from yellow to dirty brown in color and represent the defense of the skin to long-continued pressure and friction on that particular area. Improperly fitted shoes and light footwear that affords inadequate protection to the feet are most often responsible for the production of this lesion.

In many patients, the callosities are small and asymptomatic and thus require no treatment. On the other hand, large lesions may be extremely painful. The use of keratolytic agents or emollients to the callus or surgical trimming of the part gives temporary relief only. Callosities will gradually disappear without other treatment if the patient wears properly fitted shoes that alleviate pressure and friction. The successful management of callosities consists of prevention rather than active treatment after they are present.

Clavi

Corns, or clavi, are closely related to callosities. Clavi, however, are circumscribed, well delineated, hypertrophied areas of the epidermis, in contrast to the more diffuse involvement in callosities. The same factors of friction and pressure are productive in both, however. In contrast to callosities, which show histologic thickening of the skin, clavi show a prolongation of the epidermis into the depth of the lesion. It is this feature which accounts for the excruciating pain, noted on pressure, that characterizes most corns. Lesions located between the toes, in that en-

vironment of increased moisture and heat, undergo maceration and become soft, producing so-called soft corns. Oftentimes the judicious use of roentgen rays will give a dramatic temporary response. As in the treatment of callosities, the repetitive use of keratolytics and emollients gives only temporary relief, whereas properly fitted footwear is of prime consideration in definitive therapy.

Fig. 1. Arsenical keratosis occurring on the soles of a patient with chronic arsenism.

Verrucae

Plantar warts have a certain amount of callus associated with them, and for this reason it is difficult to differentiate them from pure callus independent of warts. Warts are caused by a virus and must be treated as an infectious disease. The virus is often implanted in normal tissue by methods of treatment that incompletely destroy them. The therapeutic problem in mosaic plantar wart, which consists of clusters of individual smaller warts grouped together, is magnified in proportion to the number of individual lesions.

Surgical excision is of questionable value in the treatment of warts because of the frequent recurrence of the lesion in the incisional scar. Electrosurgical treatment creates an ulcer which is always a hazard on the foot because of secondary infection. Bismuth, given either intramuscularly (bismuth subsalicylate in oil) or orally (bistrimate), has been of some benefit in the occasional patient. The application of various acids or carbon dioxide snow have produced such inconsistent results that these methods are not employed routinely. By far the simplest destructive modality is that of the roentgen ray. Needless to say, the multiplicity of treatments attests to the unsatisfactory results usually obtained.

After other methods of treatment have been tried without benefit, a good response is occasionally ob-

tained by massaging 10 to 20 per cent ammoniated mercury ointment into the warts. Mosaic warts, because they cover such a large area, cannot be treated in the usual manner. Keratolytic plasters, or even elastoplast adhesive applied over the warts, soften the keratogenous material so that in 5 to 7 days the macerated tissue can be removed by curettage. The reapplication of such agents followed by curettement in 5 to 7 days, repeated for a number of weeks, will sometimes completely destroy the wart. Variations of the technic have recently been described.[4]

the treatment of certain dermatoses. Tolerance for the arsenic, usually given in the form of Fowler's solution, is acquired very rapidly so that eventually large doses can be taken daily without evidence of acute toxicity. A history of arsenic ingestion is important in arriving at the proper diagnosis. Late sequelae can occur; these include hyperpigmentation of the skin, skin cancers and these peculiar keratoses of the palms and soles. The importance of this condition is that the keratosis can eventuate in skin cancer.

Fig. 2. Keratoderma diffusum palmaris et plantaris as this condition involves the sole, a, and the palm, b.

Arsenical Keratosis

Verrucous, hyperkeratotic lesions are seen on the palms and soles in patients with chronic arsenism (fig. 1). Arsenic is still employed today as a spring and fall tonic and in

Keratoderma Plantaris

Other hyperkeratotic lesions of the soles may be confused with multiple isolated warts. Among these is keratoderma diffusum palmaris et plantaris (fig. 2). As the name

indicates, discrete hyperkeratotic papules are diffusely present over the palms and soles. The individual lesions vary from 1 mm. to several millimeters in diameter and have a peculiar translucent quality. This is considered a hereditary disease, although on many occasions no familial incidence of the disease is found. Symptoms arise when individual lesions enlarge to a size that pressure from walking or using the hands causes pain.

At times the entire sole may show a hyperkeratotic reaction and examination of the palms shows a similar state. It is this form of keratoderma palmaris et plantaris in which a positive family history is invariably found, with numbers of each generation being involved. In all of the hereditary keratodermas, treatment is of little benefit. At best, only symptomatic relief can be obtained with the use of various keratolytics and emollients. In a symmetrical keratoderma of the soles, the palms should be examined for evidence of involvement.

Psoriasis

Keratodermas of the soles and palms are seen as part of more extensive skin diseases and incidental to lesions elsewhere on the glabrous skin. In psoriasis, somewhat hyperkeratotic lesions of the soles and palms may be present (fig. 3*a*), and here again examination of the remainder of the skin is helpful in deciding on the cause of the eruption on the feet. Psoriasis is characterized by erythematous scaling plaques present anywhere on the body but more frequently over the bony prominences. The elbows and knees are commonly involved, and these areas should be inspected for evidence of psoriasis as an aid to diagnosis.

Fig. 3. a. Psoriasis of the instep area of the foot. b. Far-advanced psoriatic changes in the toenails.

Psoriatic changes in the nails help to confirm the diagnosis. In the earliest stage, onycholysis of the lateral portions of the nails is seen, with leukonychia occurring where the nail is elevated from its bed. White, amorphous keratogenous material collects in these newly formed recesses. Small pits can be

seen scattered over the nails, sometimes isolated, at other times in a linear arrangement. When the nail involvement is maximal, yellow discoloration, marked thickening and dystrophy of the nails are seen. (fig. 3*b*).

Occasionally, a pustular form of psoriasis involves the soles and palms. On the feet, the instep area and lateral surfaces of the heels are most commonly affected, with well-delineated, erythematous patches studded with deep-seated pustules 1 to 2 mm. in diameter being present. Difficulty arises in differentiating this eruption from tinea pedis, but the presence of psoriatic lesions elsewhere on the body may be helpful in excluding the latter disease.

Lichen Planus

Lichen planus may present a keratoderma of the soles and this disease is difficult to differentiate from other hyperkeratoses by inspection of the soles alone. Lichen planus is characterized by the presence of violaceous flat-topped polygonal papules occurring about the wrists and ankles. The individual lesions may remain discrete or become confluent to form ringed lesions or plaques. The violet color of the involved skin is the outstanding feature. In the attempt to differentiate the various keratodermas, it is well to examine the other available areas of the skin. Treatment of all skin lesions, both in psoriasis and in lichen planus, is necessary to resolve the involvement of the soles.

Discoid Lupus Erythematosus

Only rarely is discoid lupus erythematosus seen on the soles. Characteristic skin lesions which show plugging, scaling, atrophy and scarring may not be present on the feet but are visible over the exposed areas of the face, neck and upper extremities. Excessive exposure to the sun has been considered an aggravating factor in lupus erythematosus and, for that reason, the occurrence of lesions on the soles is a bit difficult to explain.

Fig. 4. Lesions of granuloma annulare involving the dorsum of the hands. Similar lesions may occur on the dorsum of the feet.

Granuloma Annulare

One of the dermatoses that involve the dorsa of the feet rather than the soles is granuloma annulare (fig. 4). Involvement of the dorsa of the hands and feet commonly occurs, although all areas of the body can be affected. The primary lesions consist of small reddish-brown nodules which coalesce to form annular or ringed lesions. They enlarge by peripheral extension, concomitant with central clearing. When typical lesions are not present on the feet, inspection of the hands may reveal classic lesions which make the diagnosis evident. Symptoms are absent as a rule. The cause of the disorder is not known and treatment is, for the most part, unsatisfactory.

Nevi and Neoplasms

Neoplasms, both benign and malignant, occur on the feet, with this location exerting no influence on the frequency of their occurrence. Pigmented nevi are seen on the feet perhaps as frequently as are any of the benign neoplasms. If the nevus is a papillary growth easily palpable, with the actively growing portion of the lesion in the dermis, it is referred to as a dermal nevus. Such lesions are considered benign and their removal is an optional procedure.

Quite in contrast is the deeply pigmented macular lesion whose growth is occurring at the epidermal-dermal junction. These lesions are easily seen but lack elevation, so that they are not palpable. They are referred to as junctional nevi and are important inasmuch as they are the lesions that tend to develop into malignant melanomas. Junctional nevi subjected to trauma because of their location on the soles and palms have been found to develop into malignant lesions more often than if present elsewhere on the body. For this reason, surgical excision of junctional nevi on the soles and palms is recommended.

The patient who has a malignant melanoma has a poor prognosis for life. Melanomas are characterized by circumscribed pigmented areas which may be macular or slightly nodular in character (fig. 5*a*). The pigmentation may be somewhat mottled, and because of the depth of some of the melanin, the lesion has a blue-black color. Depending on the age of the lesion and its rate of growth, ulceration may occur. Complete surgical excision with or without lymph-node dissection seems to be the treatment of choice. Melanomas are invariably radioresistant and thus the use of x-rays can offer little reassurance to the patient.

On the rare occasions when pigment is not present in the melanoma, the lesion is referred to as an amelanotic melanoma. This lack of pigment does not alter the serious implications of the malignant process.

To be differentiated from the malignant melanoma is the benign blue nevus (fig. 5*b*). The latter lesion is characterized by its steel-blue color, which occurs because of the relative great depth of the melanin pigment in the cutis. Blue nevi are well-circumscribed, slightly elevated, buttonlike lesions that rarely exceed 5 mm. in diameter. The patient invariably states that the lesion began early in life or has been unchanged for many years. Because such lesions are benign, their removal is optional.

Also confused with malignant melanoma are the early lesions of Kaposi's hemorrhagic sarcoma. The earliest lesion noted is a bluish discoloration of the skin that develops gradually into a nodule. The in-

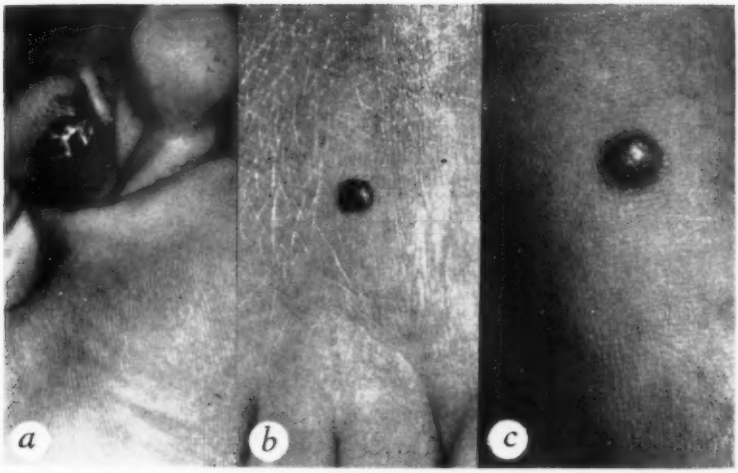


Fig. 5. a. Malignant melanoma of the toe. b. Benign blue nevus of the dorsum of the foot. c. Nodular subepidermal fibrosis of the ankle.

dividual lesions may be discrete and isolated or become confluent, with the development of indurated plaques. With the visible growth of lesions on the skin, there is always concomitant involvement of the deeper tissues about the lymph channels that leads to marked edema of an extremity if lesions are located in its proximal portion. Although the legs are the commonest sites of involvement, lesions may be present anywhere over the body and in any of the internal organs. The fact that most of these patients are of a middle European descent has never been adequately explained. Kaposi's sarcoma is slowly progressive, the course of the disease extending over 10 or 15 years. Roentgen therapy offers the best method of treatment.

One of the benign lesions seen about the foot is the nodular subepidermal fibrosis or histiocytoma. The lesion consists of a hard, firm nodule, located in the dermis, that is firmly attached to the epidermis (fig. 5*c*). The overlying epidermis usually has a brownish-red hue, often with a varnished appearance. Minor trauma such as a mosquito bite or a scratch initiates this lesion which is, for all essential purposes, subepidermal scar tissue. For the occasional lesion that is painful, surgical excision is the recommended treatment.

Stasis Dermatitis

Chronic venous insufficiency, as a single cause, is probably responsible for most of the skin lesions that we see on the lower part of the legs. Because of incompetency of the valves of the veins, the hydrostatic balance of the vascular system is disturbed, with edema of the tissues occurring very readily. After edema has been present for some weeks, a dermatitis appears that is characterized by erythema, weeping, scaling and crusting. Only after long-continued venous insufficiency for weeks, most often for months, are sclerosis, hyperpigmen-

tation and ulceration, or combinations of these, likely to occur. From the foregoing statements, it is evident that therapy of chronic venous insufficiency is directed toward control of stasis of venous blood in the legs. Characteristically, elevation of the legs relieves the congestion and re-establishes a normal situation in regard to vascular pressure, and the edema accordingly disappears. Elastic bandages worn whenever the patient is up and about suffice for such control if the condition is not far advanced. In the more severely involved patient, rest in bed with elevation of the feet and legs and soothing wet dressings and ointments are required to bring about reversal of the skin changes. Surgical removal of the damaged veins is eventually required.

Metabolic Diseases

There are a number of systemic diseases whose predominant cutaneous signs are localized to the lower part of the legs. The so-called metabolic diseases are noteworthy in this respect. Skin lesions referred to as necrobiosis lipoidica diabeticorum can occur in patients with diabetes mellitus. These lesions may be located over the feet, although they more commonly occur on the lower part of the leg. They consist of well-circumscribed sclerotic plaques that have a glistening yellow hue centrally and a dull erythematous or violaceous hue peripherally. In older lesions, telangiectatic vessels can course over the surface of the plaque, and ulcerations may be present. Although a history of diabetes mellitus helps establish the diagnosis, it must be kept in mind that not all patients with necrobiosis lipoidica diabeticorum have diabetes.

At times, nonpitting, flesh-colored to red plaques and doughy nodules are noted over the pretibial areas of the legs. The surface of the plaques becomes indented about the hair follicles and gives a pigskin appearance to the surface

Fig. 6. a. Large xanthic tumors of the Achilles tendons. b. Xanthomata of the dorsum of the fingers. Similar lesions can occur on the toes.

of the lesions. That condition is referred to as localized myxedema and is seen most commonly in patients who have been treated for toxic goiter. A similar edema of the orbital tissues, which produces exophthalmos, gives a clue to the nature of the lesions of the leg. The skin lesions are all asymptomatic and gradually disappear after a number of years. Treatment is not indicated.

Fig. 7. a. Acute gouty arthritis, first metatarso-phalangeal joint. b. Gouty tophi of the ear.

Xanthomatoses are seen in patients who have altered fat metabolism, although some patients with certain types of xanthomata have normal values for blood lipids on repeated testing. Xanthic tumors of the tendon sheaths are that form of xanthomatosis in which the lesions are seen along the course of the tendons, the Achilles tendons and those of the fingers being most commonly involved (fig. 6*a*). Nodules that are flesh-colored and contain hues of brown and yellow are seen less frequently than is a diffuse yellowish infiltrate along the course of the tendons. Local discomfort and pain when wearing shoes often bring the patient to the doctor.

Similar lesions can be noted elsewhere over joints — the knees, knuckles and elbows (fig. 6*b*). The local destruction of such lesions accomplishes little, as the xanthomata rather promptly recur in the scar within a short time. The successful management of these patients requires measures directed toward correcting the altered fat metabolism.

Not all inflammatory lesions in and about the first metatarsophalangeal joint of the foot are bunions. In gout, this joint is frequently the initial site of involvement in an acute attack (fig. 7*a*). The joint becomes swollen, tender to touch and painful, with the overlying skin being dull red to cyanotic. Rarely are the signs of acute cellulitis and lymphangitis noted. Associated systemic complaints include general malaise, headache and fever.

Gout is a hereditary disturbance of uric acid metabolism in which elevated blood levels of uric acid occur and deposits of urates are found in various tissues. Urate crystals deposited in tissues are known as tophi. Seen in the skin, tophi appear as tumefactions, the walls of which are sufficiently thinned and translucent to make easily visible the white urates that are contained therein. Sometimes, the wall of the nodule ruptures and

its chalky white contents are discharged through the opening. Tophi are commonly seen on the ears, and their presence may give visible evidence of the patient's disturbed uric acid metabolism (fig. 7*b*). With discovery of gouty tophi elsewhere on the body, the patient's complaint of pain in the bunion joint is probably likewise explained.

An attempt has been made to describe briefly the skin conditions that may occur about the feet and lower part of the legs. It is hoped that by focusing attention on the varied number of diseases that affect the foot, the chiropodist will have better definition of his field and be better able to practice his specialty.

Mayo Clinic

Summary

1. Levine, I. M., and Harris, O. T.: Chemical Sympathectomy: New Approach to Treatment of Localized Hyperhidrosis. A.M.A. Arch. Dermat. *71*: 226-230 (Feb.) 1955.
2. Gaul, L. E., and Underwood, G. B.: Primary Irritants and Sensitizers Used in Fabrication of Footwear. Arch. Dermat. & Syph. *60*: 649-675 (Nov.) 1949.
3. Shatin, Harry, and Reisch, Milton: Dermatitis of the Feet Due to Shoes. A.M.A. Arch. Dermat. & Syph. *69*:651-666 (June) 1954.
4. Prazak, George, and Thomas, D. E.: Curettage Treatment of Plantar Warts. A.M.A. Arch. Dermat. *71*:122-123 (Jan.) 1955.

COMPOSITION OF ADHESIVE TAPES

GENERALLY speaking, adhesive tapes are prepared from elastromers, resins, plasticizers and fillers.

The approximate composition is 33% elastomer, which could be natural rubber or synthetic rubber, depending upon the properties desired. The purpose of the elastomer is to provide the film former which will hold the adhesive on the cloth for a period of time.

Approximately one-third of the adhesive composition is resin. This may vary from the resin used in the early days to the stabilized synthetic resins of today. The purpose of the resin fraction is to provide the "tack" of the adhesive.

The remaining one-third of the adhesive is composed of fillers and plasticizers, which vary in composition depending on the desired softness of the adhesive. The filler is generally zinc oxide or clay and the plasticizer may be lanolin, pine tar or similar materials.

The backings used for adhesive tape are generally fabrics ranging from 80 x 80 cloth to 76 x 84 cloth. They usually possess a tensile strength of from 45 to 60 pounds per inch and they weigh from 3 to 4 ounces per inch. Some of these cloths are coated with plastic compositions of nitrocellulose or ethylcellulose in order to give them a higher degree of washability and also render them water repellent.

AN ORTHOPEDIC METHOD AND APPLIANCE THERAPY

ROBERT K. BUNCH, D.S.C.
Houston, Texas

The human body, in many instances, has been considered to parallel certain architectural structures. This is evidenced by the repeated attempts to treat the human foot as a static sructure rather than a dynamic articulating organ.

In years of alleviating painful functional foot disorders, strides have been made toward stabilizing the entire foot through the use of a rigid appliance. This orthodox appliance has merely tended to support the already malaligned osseous structures but little has ever been accomplished toward restoring these osseous elements into their normal anatomical attitudes.

If nature had intended for the foot to be a rigid, nonfunctioning organ, it would not have been endowed with as many functioning articulations as it now possesses.

The theory to be discussed and the specific balancing inlay employ certain features which act as fulcrums to restore the osseous structures back to their once normal positions. The balancing inlay employs active forces to bring about positional changes whereas the rigid appliance supports the already malfunctioning foot. This new type inlay is based on specific placing of the adjusting forces by use of non-weight bearing radiographs. This theory and balancing inlay has been in actual use for some thirty years. It is with the thought in mind that any therapy proven successful in private practice should be submitted for general use and appraisal.

Evidence supporting the following theory of orthopedic correction has been observed in over 10,000 clinical cases involving functional foot imbalance, over a period of more than thirty years. The usual and varied subjective and objective symptoms were recorded on the patient's clinic card with the inclusion of dorso-plantar and lateral non-weight bearing radiographs.

In walking, we assume that the body weight is transmitted through the tibia and is first received in the foot by the talus and the calcaneus. It is then directed along the outer border of the foot, which acts as a balancing medium as the weight is transmitted through the inner or medial aspect of the foot. The fact that the first metatarsal is of a larger size indicates that most of our body weight and propelling forces are generated within and along the course of this strongly built first metatarsal. The flexibility of the cuboidal fourth metatarsal and cuboidal fifth metatarsal articulations suggests that the fourth and fifth metatarsals maintain equilibrium rather than direct weight bearing.

The calcaneus is by far the largest bone in the human foot, and is so situated that it directly locks the talus into the receiving articulation of the tibia on its superior and medial aspects. The lateral or talofibular articulation, a non-weight bearing joint, does not enter into the principle of direct support of the body weight. The therapy to be discussed consists primarily of placing the adjusting force beneath the antero-inferior aspect of the calcaneus. This adjustment or calcaneal bar acts as a fulcrum in order to maintain weight bearing on the calcaneal tuberosity, thereby performing its normal function.

In the evolution of man, certain basic facts and fundamental prin-

ciples must be considered. One is that the delicate cranial tissues are enclosed and thereby protected by the bony skull which serves as a protective vault. The heart and lungs are protected by the thoracic cage, consisting of the ribs, sternum and vertebrae. Likewise, the body musculature has been developed and placed in unique positions to provide the best body dynamics. By accepting the tripodal principles or theorem of weight bearing in the human foot, we find on evidence of direct osseous pressure being exerted on any of the body musculature. The Bunch Method of correction stays in accordance with the above principle by not placing the weight bearing pressure upon muscle, nervous or vascular tissues.

This appliance is not intended to supplant other necessary types of orthopedic inlays but it has a definite place among our modern orthodox appliances. The appliance is made according to the radiographic findings of each individual patient. The many angular variations of the calcanei observed on lateral views would indicate that this appliance would be quite accurate in instituting these supportive measures. Strong evidence points to a belief that foot elongation precedes foot pronation. By limiting elongation, we must surely limit or prevent foot pronation. Diagnosis and symptom evaluation are imperative in each case. In taking the case history on the initial visit, an indication of positive foot imbalance is the statement that longer and narrower shoes are being required. This should lead one to believe that an excessive elongation is taking place.

The variations in non-weight bearing lateral radiographs of the calcaneo-cuboidal and the talo-calcaneal articulations, indicate the absence of ligamentous tone. The greater the separation between the bones at these articulations, the more ligamentous strain is present.

A number of cases presented with concomitant low back pain in the sacroiliac region were relieved when this method of therapy was instituted. This supports the common belief that positional osseous changes and deviations occurring in the lower extremities may produce effects elsewhere in the body.

The radiographic technique employed is the non-weight bearing position and consists mainly of two views; dorso-plantar and lateral. For the dorso-plantar view, the patient should lie on his back. In radiographing the right foot, the leg should be so flexed that the sole of the foot rests upon the cassette or film holder. The knee should be in a perfectly straight line from the center of the popliteal fossa to the mid-line of the posterior aspect of the heel. The x-ray cone should be focused at the bases of the first and second metatarsals at their articulations with the first and second cuneiforms.

When taking the lateral view of the right foot, the patient should be lying on his right side with the leg slightly flexed on the thigh. The knee and the lateral (fibular) malleolus should be at rest on the x-ray table. The x-ray cone for this view should be focused at the calcaneo-cuboidal articulation. The radiographs to be taken are right and left, dorso-plantar and lateral, non-weight bearing. The type film, time and distance are standard.

The standard appliance has a certain basic construction. Flat inside plates, which provide the stable foundation for the adjustments are used. These plates are composed of a combination cloth and plastic or hardened material 1/32" thick. This width plate is used in most all cases excepting pa-

tients who are employed in manual labor or walk excessively, then a 1/16" plate has been found to be more suitable or durable. These inside plates are of suitable sizes to conform to the innersole of the patient's shoes. The fitting is begun by the selection of the proper length, width, and thickness of the inner plate measured to the plantar non-weight bearing surface of the patient's foot. These approximate sizes are then fitted in length to the radiograph of the patient's foot. The lateral view determines the length while the dorso-plantar view allows the following of the anterior transverse metatarsal arch. The plastic inner plates, after being fitted to the foot outline and the radiographs, should be symmetrical and follow very closely the innersole of a functional shoe. The inner plates are then sandpapered, leaving no sharp edges, and finally cemented top and bottom.

The adjusting pads for the metatarsal raises are of the orthodox type and thin rubber metatarsal pads may be used for the calcaneal adjustment. The positioning of the calcaneal adjustment is determined by holding the inner plate next to the lateral radiograph. The calcaneal pad is placed just anterior to the calcaneal tuberosity but care must be taken that it is not carried too far anterior as to interfere with the projecting cuboidal prominence.

The metatarsal pads are positioned according to each dorso-plantar radiographic view, that is if the metatarsal heads are in a juxtaposition and the specific interspace is to be widened, the metatarsal pad should have its highest point beneath the offending metatarsals, just posterior to the metatarsophalangeal articulation and joint capsule.

The build-ups are thus placed in positions to assist in the restoration of normal foot balance. The bottom covering material may be a thin sheet rubber or suede leather. The conventional top materials are light-weight calf, kidskin, patent leather or plastic. After the posterior calcaneal and the anterior metatarsal adjustments are adhered to the inner plate by rubber cement, the tops and bottoms are applied by the same process, crimping the edges to the outline of the inner celastic plate. A margin of 1/8" should be allowed around the celastic plate with a 1/2" allowance at the anterior extension of the inlay. The anterior extension should then be skived to a smooth finish on the undersurface.

When making the inlay, if there is a deep nucleated tyloma beneath an involved metatarsal head, an 1/8" or 1/4" rubberfoam extension may be incorporated. Small medial or lateral cork elevations or rubber build-ups may be employed for temporary balancing in conjunction with the regular calcaneal adjustments. The calcaneal adjustments may be cemented directly into the shoes without the use of the complete inlay. These calcaneal adjustments will not alter the qualities of functional shoes.

Perhaps one of the greatest errors in treating foot imbalances is overcorrection. The best results are obtained by using minimal height adjustments with changes at timely intervals. The adjustments should never be corrected while the patient appears asymptomatic and the adjustment changes should be spaced at monthly intervals so that the soft tissue structures can adjust to the repositioning of the skeletal structures.

Therapeutic Indications

Weakfoot and Degrees Thereof:

Primary Weakfoot: There may be a mild elongation of the feet

when the patient is standing or walking. There may be occasional leg pains or the subjective symptoms may be altogether absent. Ingrown toe nails are a frequent symptom, as the result of an elongation of the foot. Quite often, the shoe size has been lengthened and narrowed, evidence that an elongation is taking place. The radiograph depicts some osseous separation of the calcaneo-cuboidal articulation while there may be a frequent reduction of certain metatarsal head interspaces. In construction of the appliance, emphasis is stressed on the posterior or calcaneal adjustment, beginning with a mild raise (1/16"-1/8"-1/4"), depending upon the weight and occupation of the patient. This adjustment is increased in height gradually, usually at monthly intervals until the patient appears asymptomatic.

Secondary Weakfoot: This has as its symptomatology, an excessive elongation accompanied by a pronation which may be moderate or extreme. The term pronation referring to an eversion of the calcaneus with a concomitant abduction of the forefoot. The moderate types of pronation are handled quite successfully with the calcaneal bar. The more severely pronated feet may require a well-constructed shoe having a long inside counter and a Thomas heel in addition to the calcaneal bar. Observe the footgear at monthly intervals. The most extreme cases of foot pronation are more successfully handled through the application of the Royal Whitman or Robert's Brace. The application of inlays and proper footgear should be instituted at the beginning of treatment or as shortly thereafter as possible.

Metatarsalgia: The symptomatology of this condition consists mainly of pain in the metatarsal region with pronounced tenderness between the metatarsal heads, which may be elicited upon digital palpation. The radiographic visualization shows a definite positional change in the calcaneo-cuboidal articulation. These are two types of metatarsalgia: The first type will usually show well-balanced metatarsal head interspaces. The pain is due to pressure on the plantar

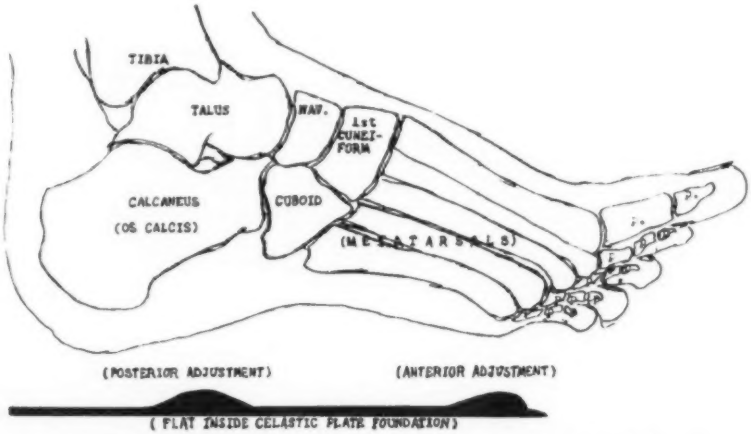


Fig. 1. Relationship of appliance to lateral view of foot.

nerves at the cuboidal area, irritating the articulating branches of the medial plantar nerve which supplies the tarsus and metatarsus. This in turn may produce referred pain in the anterior metatarsal head region. The second type metatarsalgia originates frequently from lateral nerve pressure, due to variations of the metatarsal head interspacings.

Construction of the appliance for Type One metatarsalgia: Stress must be directed at controlling the position of the calcaneus, which directly controls the positioning of the cuboid through its articulation, and will eliminate nerve pressure from that source.

Construction of the appliance for Type Two metatarsalgia: The posterior aspect of the foot is controlled by the calcaneal adjustment and the metatarsal pads are placed in the proper position to widen the interspaces involved.

Pes Cavus: Frequently, the patient is found to be almost completely asymptomatic. Secondary symptoms may include pain in certain metatarsal areas, namely one, two or five. An exceptionally high angulation of the calcaneus is observed on a lateral radiograph and the metatarsal head interspaces are usually rather well spaced. In the construction of the inlay, a low or medium height posterior or calcaneal bar is employed with a large metatarsal pad placed inferior and posterior to the involved metatarsal heads. This will tend to stretch the plantar structures to some extent.

Morton's Syndrome: This may sometimes be included under a phase of metatarsalgia involving a concomitant hypermobility of the first metatarsal segment. The calcaneal adjustment is employed to prevent a forward elongation whereby a specific metatarsal adjustment may be made. Either of

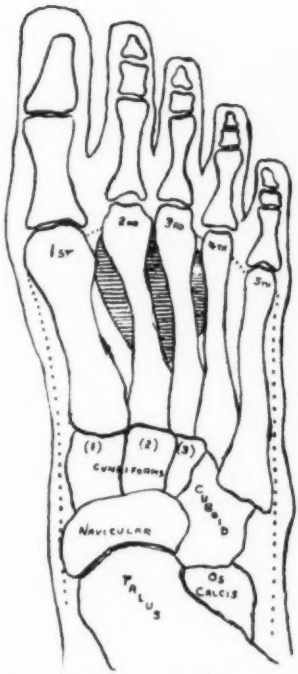


Fig. 2. Outline of celastic plate represented by dots. Hatching indicates placement for juxtaposition of 2nd and 3rd heads.

two types of an anterior adjustment may be made. A large metatarsal pad may be placed beneath and just posterior to the second metatarsal head or a shelf-like build-up may be extended forward beneath the first metatarsal shaft and head.

Calcaneal Spurs or Calcaneal Periostitis: The symptomatology may consist of pain involving the entire area of the calcaneus or it may be localized at the site of the spur or exostosis. The many instances of spur formation leads one to believe that the calcaneal spur is of little significance in diagnosis because the patient is asymptomatic in the majority of the cases. On

(Continued on Page 180)

JOURNAL

OF THE

NATIONAL ASSOCIATION of CHIROPODISTS

PUBLISHED UNDER THE DIRECTION OF THE EXECUTIVE COUNCIL
BY THE NATIONAL ASSOCIATION OF CHIROPODISTS

A. RUBIN, D.S.C., *Editor*
3301 SIXTEENTH STREET, N. W.
WASHINGTON 10, D. C.

Address all communications intended for publication, matter relating to advertising, business or subscriptions to the Editor.

PRESIDENT'S MESSAGE

THE SUN is shining, it's a beautiful day and spring fever is just around the corner. One of the best cures for this seasonal affliction I know of is to pack up and attend one of the regional conventions that are now sprouting "come hither" publicity.

Our office is still deluged with correspondence on National affairs and two situations are becoming prominent through their repetition. One is the growing need for a new name for our profession which would signify the fact that we treat all the foot instead of just corns and calluses —one that incidentally would be different in spelling and not akin to chiropractor.

Hospital connection is still a paramount issue—when and where can we get into hospitals and whether osteopathic or medical. Most of the men writing in, lose sight of some very important facts. First, our minimal amount of hospital training generally and second that the hospital which does accept us to do any work at all does so as a "courtesy."

Our inclusion in any hospital is strictly on a guest basis. Who are we to criticize a hospital group, osteopathic or medical when we as a profession cannot show a single hospital of our own?

It is indeed a pleasant thought to feel that someday our colleges will have funds to be able to turn their clinics for student training into foot hospitals, for the use of the students and profession alike. On this basis our training would become more complete and our general acceptance more quickly secured.

By the time this letter is in print yours truly will be attending one of the regional meetings. Maybe I won't have the time to learn much, but at least I'll meet some of my "Ole Buddies" I haven't seen for a long time. Also I've never yet attended a meeting without getting at least one idea that helped boost my practice.

RALPH E. FOWLER

STEPPING UP TO A CAREER

Have you given any thought to Chiropody as a career?

"CHIROPODY is that specialty of medicine and surgery which is concerned with the care of human feet in health and disease."

The DOCTOR OF SURGICAL CHIROPODY is the foot specialist. His scope of practice includes the prevention, diagnosis, and treatment of foot disorders.

The profession of chiropody is a rapidly growing branch of the healing arts, and it is one of the least crowded of the professions. (A few states use the synonym Podiatry for the word Chiropody.) The National Association of Chiropodists estimates that an additional 3,000 chiropodists will be needed by 1960. The young man or woman interested in the healing arts would do well to consider the profession of chiropody as a career. Foot health is as essential to modern living as is general medical and dental health. The services of a chiropodist are needed wherever people live. As a member of a profession, the chiropodist (podiatrist) rapidly earns a position of high respect in his community.

Opportunities for the DOCTOR OF SURGICAL CHIROPODY (PODIATRY) are unlimited. It is conservatively estimated by the United States Department of Public Health that approximately 80% of the 160 million people in the United States have suffered, at one time or another, from some form of foot ailment. People need foot care as foot disabilities handicap them in their daily activities.

The United States Department of Labor and the American College of Surgeons have issued statistics which indicate that foot problems cost industry hundreds of millions of dollars a year.

The National Association of Chiropodists believes this figure to be about 600 million dollars annually. Many industries recognize this fact and have added chiropodists to their medical staffs.

THE CHIROPODIST— WHAT DOES HE DO?

The professional training that a chiropodist (podiatrist) receives prepares him to be a foot specialist. He is taught to diagnose and treat foot infections, tumors, fractures, skin and nail diseases, congenital and acquired deformities, ulcers, and imbalance of the feet. With his background the chiropodist is able to detect those constitutional or general diseases that present symptoms in the feet. In arriving at a diagnosis and in treating foot conditions, the chiropodist uses all of the laboratory tests, and the electrical and mechanical devices that are at the disposal of any doctor in the healing arts. Surgery, x-rays, medications, injections, anesthesia, blood tests, urinalysis, cultures for bacteria and fungii, braces, plaster of Paris casts, splints and foot appliances and others are used when indicated.

PRACTICE—WHERE AND WHEN?

The DOCTOR OF SURGICAL CHIROPODY works under conditions that may be considered ideal. He is self employed, giving him the feeling of independence which all men and women desire. He chooses not only the location of his practice but also the design and decoration of his office. Besides he selects his equipment. Regular hours are the rule in this branch of medicine. The usual work day is from 9 A.M. to 5 P.M., five days a week. Some chiropodists have office hours also one or two evenings a week. It is the extremely rare occasion that a chiropodist is called out at night.

OPPORTUNITIES

The individual who has earned the degree of DOCTOR OF SURGICAL CHIROPODY has the following work opportunities:

1. Private practice or as an associate with another chiropodist.
2. Institutional appointment, such as in hospitals, Home For The Aged, Cerebral Palsy Centers, etc.
3. Chiropodist in an industrial plant.
4. Internships and Post Graduate Work.
5. Research.
6. Commissioned officer in the Navy or Air Force.

EARNINGS

The consideration of a profession as a career should not be based on financial gain alone. The professional man, however, who has devoted his time and energies to acquire an education, has the right to expect a better than average income. No limit can be placed on the chiropodist's income. He is self employed and his earnings are in direct proportion to his efforts, energies, and enthusiasm. Incomes throughout the United States vary from $6000 to $25,000 and more a year.

QUALIFICATIONS

The entrance requirements to a College of Chiropody (Podiatry) are four years of high school and one or two years of college level work taken at an approved junior college, college, or university. Specific subject requirements are: English, zoology or biology, chemistry and physics.

The course leading to the degree of DOCTOR OF SURGICAL CHIROPODY requires four years of study in the professional school. Each year consists of about thirty-six weeks. A total of 4,300 hours are devoted to classroom, laboratory, and practical clinical instruction.

The costs of attending a chiropody college for tuition, laboratory fees, books, and instruments vary from $500 and $650 per year.

A pleasing personality with the ability to win the respect and confidence of people, plus honesty, patience, enthusiasm, cheerfulness and tact, are cardinal personality traits that a professional man should possess.

All the colleges listed here are approved by the Council of Education of the National Association of Chiropodists.

California College of Chiropody
1770 Eddy Street, San Francisco, California
Entrance Requirements—2 years college
Professional Course—Four years

Chicago College of Chiropody
1422 West Monroe Street, Chicago, Illinois
Entrance Requirements—One year college
Professional Course—Four years

Illinois College of Chiropody and Foot Surgery
1327 North Clark Street, Chicago, Illinois
Entrance Requirements—One year college
Professional Course—Four years

New York College of Podiatry
55 East 124th Street, New York, N. Y.
Entrance Requirements—Two years college
Professional Course—Four years

Ohio College of Chiropody
2057 Cornell Road, Cleveland, Ohio
Entrance Requirements—One year college
Professional Course—Four years

Temple University, School of Chiropody
1810 Spring Garden Street, Philadelphia, Pa.
Entrance Requirements—One year college
Professional Course—Four years

To obtain more detailed information regarding Chiropody education, write to the above listed colleges for catalogues.

References: "Chiropody As A Career," 27 pages, 60 cents, Park Publishing House, 4141 West Vliet Street, Milwaukee, Wisconsin.

"Chiropody As A Career", 16mm color film.

Additional copies of this folder or information on borrowing the film may be obtained from the

NATIONAL ASSOCIATION OF CHIROPODISTS
3301 16th Street Northwest
Washington 10, D. C.

PRE-PROFESSIONAL EDUCATION AND A PROFESSIONAL LIFE

THIS PAST AUTUMN we were present at the Regional Meeting of the Middle Atlantic States. There in Winston-Salem, N. C., we heard the secretary of the local Junior Chamber of Commerce address us at the banquet. This forceful speaker made the point that professional people were not accepting their responsibilities for service in the local community. They shirk their duties in church, organizational, and civic affairs. And this they do, or rather fail to do, for the very community that yields them economic sustenance; for the community that grants them social stature; for the community in whose environment they maintain and raise their families.

This past winter we participated in an Editors Conference at Atlanta, Ga., held in connection with the annual meeting of the American Association for Advancement of Science. One of the major concerns was the unsatisfactory quality of many submitted papers. (Apparently not only chiropody editors are troubled with this.) Papers are technically correct but literary failures, failing to communicate adequately the worthwhile information the writer has to offer.

The technological advances in the sciences have added up so rapidly that even the lengthening curriculum of professional schools intended to make room for the humanities, social sciences and culture in general, is failing to do this. Studies by the United States Office of Education show that some professions are beginning to stem this tide and even to reverse it. Fortunately we are not yet touched.

In our present concern regarding the content of the pre-chiropody curriculum we must not fall into the trap many of the other professions fell into. If chiropodists are to participate and assume some leadership expected of them in community affairs, they must be prepared for it. This participation is not only a duty to the community but is a duty to the profession, for it is thus that we as individuals and our profession become identified. (And there are incidental immediate personal economic rewards.)

Certainly our schools must be concerned with the professional and technical education of the chiropodist. The place for his general education is in the pre-chiropody curriculum. More to the point, the pre-chiropody curriculum cannot reasonably be expected to provide enough background in some of the subjects it is expected to.

An example of this is chemistry as a prerequisite. Only a graduate chemist could have the training sometimes thought to be necessary for biochemistry. Biochemical courses in all the healing arts will have to be approached in professional schools from a clinical viewpoint and not taught as if the student were being prepared for research in the subject. Medicine has awakened in this respect. Last year Columbia University was given a grant of $2,000,000 for research into, and development of, training programs in biochemistry for medical students.

A good general pre-chiropody curriculum need not and indeed should not be weighted in the sciences. Some science may be advisable only as it pertains to a general education. But it should not be mandatory. The general education is more likely to prepare the student for the long and intensive study of a professional school and more certainly prepare him for the personal and professional communities of his professional life.

Abbott Lawrence Lowell in his inaugural address when he became president of Harvard University began with these words: "Among his other sayings, Aristotle remarked that man is by nature a social animal; and it is in order to develop his powers as a social being that American colleges exist. The object of the undergraduate department is not to produce hermits, each imprisoned in the cell of his own intellectual pursuits, but men fitted to take their places in the community and live in contact with their fellow men." Let us prepare our students not only for a living but also for living.

REPORT OF VOCATIONAL GUIDANCE COMMITTEE

Dr. L. B. Thompson, Co-Chairman
Dr. H. I. Horwitz, Co-Chairman

(Ed. Note: See "Communications to the Profession" from Co-Chairmen on Page 188.)

Objectives

1. Primary objective is to increase enrollment in the accredited chiropody colleges.
2. To acquaint the Vocational Guidance Counsellors throughout the United States of the whys, hows and wherefores of chiropody education, costs, opportunities, etc.
3. To bring to the high school, junior college and university student the opportunities of "Chiropody as a Career."
4. To have scholarships in chiropody colleges offered and subsidized by fraternities, affiliated state societies, industries related to foot health, etc.
5. To activate the state societies on a guidance program.

Plans

1. To purchase at least three copies of "Chiropody as a Career" film. These three prints to be placed in a film library. To then notify vocational guidance counsellors, high schools, junior colleges, universities, that such a film is available to them. A small charge ($2.00) is made to cover handling costs — or the National Association could pay these costs if it so wished.
2. To mail the monograph "Chiropody as a Career" to all members of the National Association of Vocational Guidance Counsellors. About 5,500 copies will be needed.
3. To word a short pamphlet on "Chiropody as a Career" directed at the high school and college student. To print 100,000 of these pamphlets. Then to sell these pamphlets at cost to our affiliated state societies, plus offering to them for every 1,000 they buy at cost the National Association will contribute 500 pamphlets free of charge. Thus the National will subsidize 1/3 of the cost of these pamphlets to the states and try to stimulate the states in a vocational guidance program. These pamphlets will also be mailed to each vocational guidance counsellor.
4. The National Vocational Guidance Association is having its convention in Washington, D. C., during March 26 through 29th at the Shoreham Hotel. The N.A.C. should have an exhibit and literature plus members of the profession present to answer questions about our profession during this convention.

This report was accepted at the Executive Council Meeting December 10-11, 1955, Woodner Hotel, Washington, D. C.

HEALTH AND ACCIDENT, INDUSTRIAL AND WORKMEN'S COMPENSATION CASES*

FRANK WEINSTEIN, D.S.C.
Edmonton, Alta., Canada

A REVIEW of the literature within our profession is significant in that, while various papers have been presented on specific injuries sustained by the feet in private life, not a single paper has been devoted to those encountered in Compensation and Insurance work. This paper then is an attempt to fill such a breach.

In addition to listing the various types of injuries met with, the author shall endeavor to present his methods to treatment, as well as the prognosis. The latter is of the utmost importance to the patient as well as the Compensation Boards and Insurance Companies.

Fractures

Many chiropodists are not prepared to undertake the treatment of a compound or green-stick fracture of any bone in the foot or ankle. The healing time of any fracture varies with age, constitution, bone involvement, and degree of trauma sustained. On the average, it may be assumed that a fracture of any pedic bone will heal from 4 weeks for a digital bone to approximately 8 weeks for a metatarsal or tarsal which bears more weight.

On the other hand, few if any chiropodists would refuse to accept a simple transverse or oblique fracture of any of the digital, metatarsal or tarsal bones, providing that approximation could be obtained by immobilization employing either felt padding or plaster of paris and supplemented by physiotherapy and rest. Again practically no chiropodist would refuse to accept an incomplete fracture, whether it be transverse, oblique or spiral since simple immobilization and rest will suffice in these instances. These injuries generally heal in half the time required for a complete fracture.

1. Digital Fractures

In addition to x-rays *the neurological tuning fork will invariably* assist the practitioner in distinguishing a suspected fracture from a simple contusion. In the former, the vibrations *serve to irritate and further separate the fragments with the net result that the patient manifests a sharp painful response;* whereas the reaction is nil or nearly normal in a contusion. The chief point of interest is not only to apply the padding to immobilize the digit, but also to *relax the reflex spasm invariably present by applying a plantar ¼" felt padding to either the medial or lateral segment of the forefoot* to neutralize that segment from undue motion. A complete digital fracture in a healthy average individual will require a minimum of three to six weeks to heal thoroughly and pain and suffering to subside. Infra-red radiation after the first week will usually accelerate the healing unless specific conditions such as age, diabetes and vascular disease exist to contraindicate their use. An x-ray plate not only determines the site and type of injury but guides the practitioner in the placement of the padding. *A transverse fracture of a digit should be padded by placing the*

*An award winning paper in the 1955 N.A.C. Research Awards

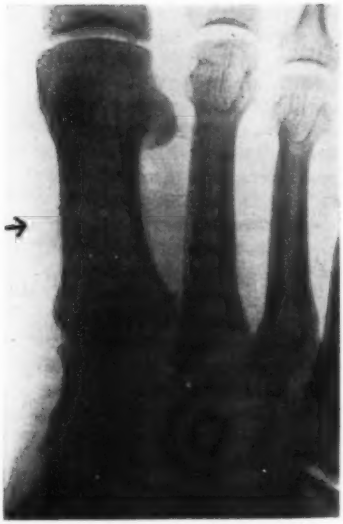


Fig. 1. Fragmentation fracture due to compression from falling object (log).

felt on the plantar surface; thus permitting the fragments to rest on the padding. *Similarly, fracture in the longitudinal axis of the digit requires the felt to be placed laterally, on the pain-free side, with tape bringing the fragments into approximation.*

2. Metatarsal Fractures

These fall within three main categories, viz:

(a) Simple Transverse Fractures: In this category fall the majority of the compensation cases which come to a chiropodist for treatment. These are the ones due to such factors as falling objects, falling, stumbling, etc. The treatment varies with the age of the patient. In a normal healthy patient in the 3rd or 4th decade of life, a fracture sans displacement requires simple ¼" felt padding to obtain immobilization of the part; resting the foot from undue stress will then suffice. Infra-red radiation after the first ten days will accelerate healing; physiotherapy administered prematurely may provoke a case of Sudeck's atrophy. In a more aged person it is therefore judicious to wait even longer than the first ten days before instituting infra-red radiation. In a child wherein torsion of the shaft may have occurred, then an appliance is required to relieve the foot yet permit locomotion in order to obtain remodeling.

(b) Compression or Fragmentation Fractures: This is one of the least common type of fractures treated by the chiropodist. Here one encounters an injury induced through trauma from a very heavy object, e.g., a heavy tree falling on a logger, etc. (See Fig. 1). Unless complications threaten, then treatment devolves on the principle of restoring function and eliminating adhesions. Initially rest and immobilization will stimulate and permit callus formation. Gradually physiotherapy and if necessary the use of hydrocortisone via injection locally with gentle manipulation will obtain a full range of motion. This type of fracture should be permitted additional time prior to discharge to heavy duty.

(c) Fractures of the tuberosities of either the base of the fifth metatarsal or the navicular, both of which are particularly prone to fracture when subjected to undue muscular tension or sudden pull.

Treatment for this type of fracture is similar to that for a simple transverse one. However the practitioner must bear in mind a word of caution—failure to properly immobilize and approximate the fragments to permit bony union will result in fibrous union instead, with its attendant pain and spasm. The time factor is also one that should be lengthened to ensure strong attachment otherwise the

callus will be weakened. These tuberosities are either strong points of tendinous attachment or weight-bearing, and as such should be respected when injured. Fracture of the fifth base is sometimes designated as the Robert Jones fracture. The principal exciting cause is usually a sudden pull or jerk with sharp pain and edema following. Fracture is often missed or not suspected, hence the importance of x-ray in these cases in arriving at the correct diagnosis cannot be too strongly emphasized. The Robert Jones fracture in particular is one which is altogether too often treated as a simple strain sans x-ray, with the net result that the patient reports in with a good case of chronic synovitis associated with fibrous union (see Fig. 2). The

Fig. 2. Fibrous union with chronic synovitis.

padding should not only be on the plantar surface of the foot but also extend laterally and liberally on either side and above the joint thus thoroughly immobilizing and approximating the fragments. In the late stages of treatment the use of sinusoidal electrotherapy which is painless is the best guide to a sound bony union.

3. Tarsal Fractures

Fractures of the tarsus may be beyond the scope of the chiropodist. However a chip fracture of the navicular is a common injury and requires but simple immobilization and rest to effect a good clinical result. The immobilization may be obtained in the form of a Campbell's strapping incorporating felt plantar padding. Fracture of the navicular tuberosity has already been referred to under tuberosity fractures.

4. Ankle Joint

Complete fractures of the tibia or fibula require open-reduction. Often however, the chiropodist is consulted for incomplete fractures which will respond to conservative treatment. Thorough examination via x-ray is very important in these cases to determine the best course of treatment as well as to avoid *medico-legal consequences as the result of inadequate treatment.*[2] All ankle fractures require additional time and elastic strapping as well as sinusoidal electrotherapy to restore normal tonus and strength to the ruptured ligaments.

Soft Tissue Injuries

1. Burns

Second and third degree burns, if at all extensive, require the services of a plastic surgeon. First degree burns, which do not extend beyond the epidermis, can and should be treated by the average chiropodist. Two features of this type of injury should constantly be borne in mind:

(a) Infection is always threatening or present hence antibiotics should be employed parenterally in liberal dosage.

(b) Shock, a delayed factor if any amount of tissue has been lost,

requires immediate bed rest with the practitioner ordering lots of fruit juices and a mild saline solution to maintain electrolytic balance of the body fluids and tissues.

2. Bursitis and Synovitis

By far the most common and frequently treated type of injury sustained in the foot and ankle. Depending upon the object causing the edema, the time factor involved, constitution and age, the treatment varies from simple protective padding and infra-red radiation to the use of hydrocortisone via injection locally to accelerate healing and reabsorption. *Radiologically the difference is that in bursitis there is simple effusion and swelling of the soft tissues subjacent to the joint; in synovitis there is to be found a symmetrical edema with a dulling or "ground-glass" appearance.*[3] The two most common sites of injury which may be efficiently handled in the office are those involving:

(a) First M-P Joint: This area can be readily eased by the use of a sesamoid pad from ¼-½" in thickness, depending upon the extent of local edema. Normal recovery sans the use of hydrocortisone requires approximately 10 days; with the use of the steroid the time factor may be halved.

(b) Ankle-Joint: *It cannot be too strongly emphasized that injuries to this area must be given additional time for complete recovery.* In addition to the use of physiotherapy and steroid injection there must also be added, compression and a high modified Gibney or Dye strapping to restrict the ankle motion to mere extension-flexion of a very limited degree. Strapping which permits any degree of lateral motion is not only useless but harmful.

Fig. 3. Helomata. Upper: Pre-operative, contrast media topically. Lower: Post-operative.

3. Helomata

While it is realized that this type of lesion in the strictest sense does not fall within the conditions listed for compensation, it does however become remunerable, under Health and Accident policies, when treated surgically. Thus a patient suffering from either an acute heloma, verruca or chronic one and who is tired of palliative painful treatment, may be offered surgical cure.

If the lesion is due to an obviously contracted dorsal tendon, a tenotomy with a skin-lengthening procedure may be suggested and performed in the office with relative safety, providing of course that the patient is fit for surgery. If the corn is associated with an enlarged condyle or phalangeal join, then resection of either part or the complete phalanx may be necessary to effect a cure. With adequate care this offers no more hazard to office surgery than soft tissue. In either case the patient may be ambulatory with light duty permitted on the third post-operative day; sutures removed by the tenth day and normal shoe wearing gradually permitted after that. Insurance companies do not hesitate to pay for a surgical cure, which requires a complete description of the operation performed by the chiropodist. Office surgery of this type which avoids undue hospital expense is particularly appreciated (see Fig. 3).

4. Infections and Wounds

The palliative or prophylactic treatment of the common helomata does not fall within the purview of either compensation or insurance cases. Many of these however become secondarily infected, and it is then that they become a matter of interest and inclusion in this paper. Simple debridement and drainage is not enough; these cases require prompt and adequate antibiotic injection therapy to overcome the deep-seated infection. In addition to this, a clean sterile dressing and protective padding is still required to obtain a good clinical result and fulfill the requirements for insurance remuneration. A number of infected heloma molle are mis-diagnosed as "athlete's foot" and only after sound treatment with dramatically quick results does the patient become aware that the prior diagnosis must have been in error.

Today, with oil-workers bringing in more and more wells on farms, it behooves the chiropodist to be alert for all puncture or lacerations of the foot in these patients. It is of the utmost importance from a medico-legal standpoint therefore that he fully inquire regarding the site on which the wound was incurred. *Any doubt about the wound being penetrated or contaminated by soil or an object exposed to the tetanus bacillus should automatically call for prolonged lavage with soap and water and the use of one of the Halogen compounds.* In addition *the wound should be left open.* Last, but not least, *the patient should be administered an intramuscular injection of 3,000 units of tetanus antitoxin* in a syringe that has been thoroughly boiled and sterilized to avoid side reaction. *Following administration of the antitoxin the patient should be observed for a minimum period of two weeks.*

5. General.

The practicing chiropodist must be on constant guard in undertaking the management of any injury or surgery if the patient is a victim of any metabolic or chronic blood disease. Diabetics, for instance, when injured require additional sugar; but often also give themselves unwanted insulin with the net result they suffer hyper-insulinism with its associated shock and

coma. Thus from a simple injury they then require hospitalization to obtain and secure metabolic balance and control. Similarly, anemics require the use of local hemostatics,* otherwise profuse capillary bleeding will ensue. Again in treating a diabetic, ordinary adhesive plaster cannot be used lest it provoke a severe skin rash with subsequent ulceration and possible infection with its grave prognosis. Thus in this type of case it is important to employ the self-adhering gauze-tape.† This will retain the pad or dressing yet not irritate the skin. This also applies to anyone with a known idiosyncrasy to adhesive plaster or zinc oxide pastes. As for *burn remedies*, while the author is well acquainted with at least a score of approved ones, he has found that an ointment consisting of *40% zinc peroxide in a zinc oxide base highly efficacious*. This remedy not only seems to avoid and eliminate local infection, but it releases nascent oxygen which is vital to normal epithelization. By cleansing the wound with hydrogen peroxide, then thoroughly covering the burn with the ointment, and occluding with sterile gauze and bandaging, *the burn need not be redressed oftener than every five days*. The average first degree burn over two square inches will require approximately three weeks to heal fully. Finally in respect to fractures it must be borne in mind that "many fractures will bear bodyweight long before the films show that union is complete."[4]

*Gelfoam, Oxycel
†Gauztex

Summary

1. A variety of conditions encountered in handling compensation and insurance cases has been presented.

2. Treatment and prognosis has been suggested.

240 Tegler Bldg.

References

1. Shanks, S. C., and Kerley, P.: Textbook of X-ray Diagnosis, p. 32, Vol. IV, 2nd Ed., W. B. Saunders Co. 1950. Philadelphia, Penn.
2. Weinstein, F.: The Relationship Between Roentgenology and Foot Orthopedics, p. 36, C.A.C.J., Fall Ed. 1951.
3. Yale, I.: Clinical and Roentgenological Interpretation in the Lower Extremities, p. 161, Chiropody Literature, 1952. Ansonia, Conn.
4. Shanks, S. C., and Kerley, P.: Textbook of X-ray Diagnosis, p. 130, Vol. IV, 2nd Ed., W. B. Saunders Co. 1950. Philadelphia, Penn.

AN ORTHOPEDIC METHOD AND APPLIANCE THERAPY

(Continued from Page 171)

radiographic visualization, the position of the calcaneus is usually altered while spurs or exostoses may or may not be present. In the construction of the appliance, a moderately soft calcaneal adjustment should not be recessed to accommodate the exostosis because when the calcaneus is restored to its normal anatomical attitude, most of the weight will be posterior to the site of the spur formation. Stabilization of the calcaneus will prevent further mechanical irritation. Suitable therapy should be instituted in most cases to alleviate any acute symptoms which may be present.

Orthodigita: — Heloma Molle: This presents a symptomatology of pain or burning at the site of the heloma molle. There is generally a normal or widened metatarsal head interspace with a wider than average separation of the calcaneocuboidal articulation. An exostosis may be present on the bone beneath the clavus. In the construction of the appliance, special care

in the alignment of the position of the calcaneus is extremely important. The minimum amount of elongation must be obtained and quite frequently, unusually high pads must be employed. The metatarsal pads must be placed with the greatest degree of caution so that they will not interfere with the balancing action of the fourth and fifth metatarsals. Shoes which are amply long and wide are definite prerequisites in the treatment.

Supplemental Therapy: Hyperkeratotic tissue or exostoses causing the same should, in all instances be reduced palliatively or surgically so that normal foot function may be restored without minor conditions interfering. Plantar helomata and minute neuro-vascular complications are relieved by small adjustments cemented on plastic plates at points which will relieve pressure while walking or standing. These may be removed after the patient becomes asymptomatic.

Physical Medicine: Medical diathermy or Microtherm is excellent for preparing the foot for function and should precede the all important foot manipulations. Foot exercises should be instituted. Age is of minor consequence provided physical impairment is not present. Normal foot articular function is restored more easily when a thorough foot manipulation is administered. Suitable foot exercises maintain skeletal movements and should be a definite part of every treatment.

Shoe Therapy: Improperly fitted shoes cause more failures in foot balance cases than do faulty appliances. It is imperative to have a suitable shoe as a foundation for this inlay and to allow normal foot function. Both shoes and stockings must be amply long and wide enough to permit normal foot function.

Special Points: Patients who are below par physically are usually difficult subjects for foot corrections. The nervous or neurotic type patient must have special care and consideration when undergoing orthopedic treatment. Foot balancing in the obese patient is much more difficult to attain than in those who are of normal or underweight. Steps must be taken to affect a proportionate weight loss prior to the institution of orthopedic correction. This is usually carried out best under the supervision of the family physician.

In podopediatrics, it has been found to be more suitable to place the adjusting pads in the shoes. This can be carried out, so that the child is unaware of the correction being made by the practitioner.

Each patient should be treated as an individual requiring special attention. After the radiographs have been taken, some time should be spent with the patient, explaining in detail the various bone alignment changes you are attempting to produce. The chiropodist should explain to his patients the normal reactions to foot orthopedic applications and he will then have the cooperative type patient.

In treating foot imbalance cases where satisfactory progress is not being made, it is well to restudy your radiographs and be sure that all articulations in the foot are freely functioning. Remove all the adjustments from the appliance, remeasure all adjustment points and begin a new series of corrections.

Suggest an immediate radiographic examination. Whether the patient has the radiographic examination on the initial visit or subsequently is of not too great importance, however, your clinical record indicates that your x-ray examination was prescribed on their first visit.

In conclusion, we may summarize that this method employs an appliance to be dispensed within a shoe.

Through this control of the rearfoot, the anterior tarsal articulations (calcaneo-cuboidal; talo-navicular; 1st, 2nd, and 3rd cuneonavicular) and the tarso-metatarsal articulations are retained in their normal anatomical positions, thus relieving strain on the involved plantar ligaments. This is accomplished without exerting pressure on the arch of the foot, in which fascia, tendons, nerves and blood vessels leading to the forefoot are disposed. This type appliance obviates the tiring effect on the foot which is sometimes common where the conventional forms of longitudinal arch supporters are employed.

An upwardly extending projection is placed anteriorly to relieve any specific metatarsal lesions present. This metatarsal correction is placed just posterior to the involved metatarsal heads and joint capsules.

The patients are instructed as to the proper type functional shoe to be worn, wearing and care of the appliance, specific foot exercises and general hygiene of the feet. Physical therapeutic aids may or may not be incorporated with the subsequent palliative chiropodical treatments.

904 Hermann Professional Bldg.

A SURVEY OF RECIPROCITY PRACTICES

L. A. HANSEN, D.S.C.*
Kansas City, Mo.

The Federation of Chiropody Boards has completed study on "Reciprocity." This was done because of the apparent need and demand for this information.

The Federation of Chiropody Boards will not and cannot tell the state boards what to do. The function of the Federation is to study the subject of reciprocity then pass its findings on to the different state boards and members of our profession.

A parallel study of the medical profession was made. According to their survey, which was published in the Journal of the American Medical Association on May 28, 1955, Vol. 158, pp. 278 and 279, it was found that only one state had no reciprocity, and that was Florida. Hawaii and the Virgin Islands were the only territories that had no reciprocal relations. According to this survey, the medical profession believes reciprocity is practical.

A questionnaire with thirty-six questions pertaining to reciprocity was sent to fifty-five boards. All were returned except one. We have found from the survey that thirty-four states and provinces out of fifty-four have reciprocity privileges. This is better than we had believed. A few of the boards that have reciprocity did not answer certain questions because they have never had an applicant for reciprocity. We hope the survey will help the state boards and the members of the profession in this problem. We have heard of states that have discontinued reciprocity and we have heard of others that do not like reciprocity for various reasons.

If a state law provides the state board with the authority to revoke the license of practitioners who are detrimental, reciprocity can be worked satisfactorily. If an individual knows that his license will

*Secretary of the Federation of Chiropody Boards.

be revoked if he does not practice according to the ethics of that state, he will either not apply for reciprocity or will conform.

Nearly every state board will welcome chiropodists from other states if they are assured that the applicants will be a credit to the profession. We must remember, however, that it is the duty of every state board to protect the people of their state as to health, welfare, and safety. Most of the state boards are very cautious. If the different states would alter their laws, more states would extend reciprocity as broadly as the medical profession.

The writer is viewing reciprocity from three levels, as a practicing chiropodist for over twenty-one years, as a secretary of a state board of chiropody for the past ten years, and the secretary of the Federation of State Boards for three years. If you have any suggestions about reciprocity, we should like to have them.

A detailed report on the survey has been sent to secretaries of the state association, national officers, colleges, editors, and members and associate members of the Federation. The following is a summary of this survey:

Question—Do you extend reciprocity?
Answer—34 yes.
Question—Fee for reciprocity?
Answer—One at $15.00; 3 at $25.00; 2 at $40.00; 11 at $50.00; 1 at $75.00; 7 at $100.00; 1 at $150.00; 1 at $200.00, and 4 blanks.
Question—Do you refund the fee if rejected?
Answer—15 yes; 8 no; 3 at $90.00; 3 discretion of the board, and 5 blanks.
Question—Is there a fee for reviewing the applicant if rejected?
Answer—One yes; 18 no; 4 at $10.00; 1 at $35.00; 1 at $40.00; and 1 at $100.00; 1 discretion of the board, and 27 blanks.
Question—Do you require the other states to extend like privileges in case of reciprocity?
Answer—27 yes; 2 no; 1 discretion of the board, and 4 blanks.
Question—Is he required to be a graduate of a recognized chiropody college?
Answer—30 yes and 4 blanks.
Question—Is he required to be a member of his chiropody association?
Answer—16 yes; 10 no; 3 discretion of the board, and 5 blanks.
Question—Number of years he is required to be a member of his chiropody association?
Answer—One at 2 years; 1 at 3 years; 1 at 5 years; 4 discretion of the board, and 27 blanks.
Question—Is he required to have a D.S.C. degree?
Answer—27 yes; 2 no; 1 discretion of the board, and 4 blanks.
Question—Do you require that he has already passed a written examination in the state from which which he is reciprocating?
Answer—28 yes; 1 no; and 4 blanks.
Question—Is it necessary for the board from which he is reciprocating to furnish a report on suspensions, etc., of the applicant?
Answer—27 yes; 1 no; 1 discretion of the board, and 5 blanks.
Question—Will you consider an applicant for reciprocity if he fails in your written examination?
Answer—One yes; 25 no; 2 discretion of the board; 1 in 10 years, and 5 blanks.
Question—Is he required to furnish proof of his pre-chiropody education?
Answer—25 yes; 5 no, and 7 blanks.
Question—Is he required to furnish proof of his chiropody college education?
Answer—31 yes; 3 blanks
Question—Is he required to furnish his professional card?

Answer—12 yes; 16 no; 6 blanks.

Question—Is he required to furnish his stationery?

Answer—12 yes; 18 no, and 4 blanks.

Question—Is he required to furnish his display advertising?

Answer—11 yes; 17 no, and 6 blanks.

Question—Is he required to furnish his telephone directory?

Answer—11 yes; 18 no, and 5 blanks.

Question—Is he required to furnish his circulars?

Answer—11 yes; 18 no, and 5 blanks.

Question—Is he required to furnish his recent photograph?

Answer—28 yes; 3 no, and 3 blanks.

Question—Is he required to furnish a photostatic copy of his college diploma?

Answer—21 yes; 6 no; 4 discretion of the board, and 3 blanks.

Question—Is he required to furnish a photostatic copy of his state license?

Answer—18 yes; 9 no; 4 discretion of the board, and 3 blanks.

Question—Is he required to sign an affidavit of ethical practice?

Answer—24 yes; 8 no, and 6 blanks.

Question—How long is he required to practice before reciprocating?

Answer—2 at 1 year; 4 at 2 years; 2 at 3 years; 9 at 5 years; 6 discretion of the board, and 11 blanks.

Question—Is he required to appear before the board?

Answer—20 yes; 9 no; 1 at discretion of the board, and 4 blanks.

Question—Is he required to take an oral examination?

Answer—12 yes; 15 no; 4 discretion of the board, and 3 blanks.

Question—Is he required to take a practical examination?

Answer—3 yes; 20 no; 6 discretion of the board, and 5 blanks.

Question—Is he required to have a character investigation by the Federation of Chiropody Boards?

Answer—7 yes; 16 no; 4 discretion of the board, and 7 blanks.

Question—Is he required to have a physical examination?

Answer—4 yes; 25 no, and 5 blanks.

Question—Is he required to be fingerprinted?

Answer—One yes; 28 no; 1 discretion of the board, and 4 blanks.

Question—If a state recently passed reciprocity, would you recognize that state?

Answer—14 yes; 12 discretion of the board, and 8 blanks.

Question—If a state recently re-repealed reciprocity, would you reject that applicant?

Answer—20 yes; 2 no; 4 discretion of the board, and 8 blanks.

Question—Do you consider it unethical to practice in a commercial place of business?

Answer—24 yes; 1 no; 1 discretion of the board, and 8 blanks.

Question—Do you consider it unethical to sell shoes in a chiropody office?

Answer—14 yes; 9 no; 2 discretion of the board, and 9 blanks.

Question—Does your board charge for the grades of the applicant who wants to reciprocate?

Answer—12 yes; 14 no, and 7 blanks.

Question—If so, what is the fee?

Answer—One at $1.00; 1 at $3.00; 4 at $5.00; 7 at $10.00, and 21 blanks.

800 Professional Bldg.

DIRECTORY OF COUNCILS AND COMMITTEES

Council on Education
Dr. Max Speizman, Chairman, 109 S. Franklin St., Wilkes-Barre, Pa.

Council on Scientific Sessions
Dr. Raymond K. Locke, Chairman, 134 Engle St., Englewood, N. J.
Committees:
Research—Dr. William F. Eads, Chairman, 1651 Garnet St., San Diego, Calif.
Technical Developments—Dr. Ellsworth R. Johnson, Chairman, 314 May Bldg., Charleston, W. Va.
Foot Surgery—Dr. William A. Edwards, Chairman, 150 Chestnut St., Reno, Nevada
Roentgenology—Dr. Howard H. Johnson, Chairman, 222 N. Independence, Enid, Okla.
Foot Orthopedics—Dr. Philip R. Brachman, Chairman, 25 E. Washington St., Chicago, Ill.
Hospital Chiropody—Dr. James W. Carby, Co-Chairman, 312-313 12th and Walnut Bldg., Kansas City, Mo.; Dr. Leo N. Liss, Co-Chairman, 209 Post St., San Francisco, Calif.
Pharmaceutical—Dr. Harry L. Hoffman, Chairman, 1098 National Press Bldg., Washington, D. C.
Shoes—Dr. Gordon R. Tobin, Co-Chairman, 153 3rd Ave. No., Twin Falls, Idaho; Dr. Benjamin C. Mullens, Co-Chairman, Security Bldg., Binghamton, N. Y.
Scientific Program—Dr. Earl G. Kaplan, Chairman, 14608 Gratiot Ave., Detroit, Mich.
Children's Foot Health—Dr. John T. Sharp, Chairman, 409 York Rd., Jenkintown, Pa.

Council on Journalism
Dr. Walter C. Gigerich, Chairman, Arkansas National Bank Bldg., Hot Springs, Ark.
Committees:
Publications—Dr. Harold M. Plaster, Chairman, 316 Frisco Bldg., Joplin, Mo.
Nomenclature—Dr. Peter N. Varzos, Chairman, 25 E. Washington St., Chicago, Ill.
History—Dr. Charles E. Krausz, Chairman, 926 W. Lehigh Ave., Philadelphia, Pa.

Council on External Affairs
Dr. James A. Conforti, Chairman, 767 Broadway, Bedford, Ohio
Committees:
Medical Relations—Dr. Harold E. Wheeler, Chairman, 3959 N. Lincoln Ave., Chicago, Ill.
Nursing Relations—Dr. Lon H. Cooper, Chairman, 346-352 Ohio Bldg., Sidney, Ohio
Industrial Relations—Dr. James A. Conforti, Chairman, 767 Broadway, Bedford, Ohio
Commercial Relations—Dr. Albert R. Brown, Chairman, 8028 W. Vernor Highway, Detroit, Mich.

Council on Foot Health Information
Dr. Alec C. Levin, Chairman, 1835 Eye St. N.W., Suite 932, Washington, D. C.

Committees:

Public Education—Dr. H. L. Collins, Chairman, 318 E. State St., Columbus, Ohio

Public Relations—Dr. Burdette L. Anderson, Chairman, 21535 Lorain Rd., Fairview Park, Ohio

Audio-Visual—Dr. Marvin W. Shapiro, Chairman, 1059 Spitzer Bldg., Toledo, Ohio

Council on Legislation

Dr. Morse K. Upshaw, Jr., Chairman, 511-513 Lamar Life Bldg., Jackson, Miss.

Committees:

Federal Affairs—Dr. Charles Turchin, Chairman, 818 18th St. N.W., Washington, D. C.

State Affairs—Dr. Joseph F. Healy, Chairman, 30 Court St., Westfield, Mass.

Military Affairs—Dr. Charles R. Brantingham, Chairman, 311 Security Bldg., Long Beach, Calif.

Council on Membership

Dr. Harry I. Horowitz, Chairman, 30-96 Steinway St., Astoria, L. I., N. Y.

Committees:

State Society Membership—Dr. Sam C. Abdoo, Chairman, 2125 David Stott Bldg., Griswold and State Sts., Detroit, Mich.

Vocational Guidance—Dr. L. B. Thompson, Chairman, 705 Kenosha National Bank Bldg., Kenosha, Wis.

Students Organization—Dr. M. D. Marr, Co-Chairman, 204 Paramount Bldg., Cedar Rapids, Iowa; Dr. Donald Altman, Co-Chairman, 767 Lexington Ave., Rm. 403, New York, N. Y.

Ethics—Dr. Ronald E. Fields, Chairman, 224 Bennie Dillon Bldg., Nashville, Tenn.

Chiropodical Assistants—Dr. Wilma J. McCullough, Chairman, 959 Park Ave., Meadville, Pa.

Council on Internal Affairs

Dr. Edgar P. Erickson, Chairman, 706-708 Mohawk Bldg., Spokane, Wash.

Committees:

Professional Economics—Dr. B. C. Egerter, Chairman, 503-506 May Bldg., Pittsburgh, Pa.

Library and Museum—Dr. Charles E. Krausz, Chairman, 926 W. Lehigh Ave., Philadelphia, Pa.

ACCREDITED CHIROPODY COLLEGES

California College of Chiropody
1770 Eddy Street
San Francisco, Calif.

Chicago College of Chiropody
1422 West Monroe Street
Chicago, Ill.

Illinois College of Chiropody and Foot Surgery
1327 North Clark Street
Chicago, Ill.

New York College of Podiatry
53 East 124th Street
New York, N. Y.

Ohio College of Chiropody
2057 Cornell Road
Cleveland, Ohio

Temple University, School of Chiropody
1810 Spring Garden Street
Philadelphia, Pa.

PHARMACEUTICAL PREPARATIONS FOR THE PROFESSION

Harry L. Hoffman, Ph.G., D.S.C.
Chairman Council on
Chiropodical Therapeutics and
Pharmacy

A column devoted to preparations, new and old, with emphasis on their value and uses in everyday chiropody practice. This will be a regular monthly column and we invite questions, which we shall endeavor to answer, or obtain the answer.

Pabalate HC Tablets

Description: Each light blue tablet contains; Hydrocortisone 2.5 mg, potassium salicylate 300 mg, potassium p-aminobenzoate 300 mg, ascorbic acid 50 mg.

Indications: Rheumatoid and other forms of arthritis, acute rheumatic fever, bursitis, neuritis and fibrositis.

Administration: Two tablets four times daily; smaller doses for children.

How Supplied: Bottles of 100 tablets each.

Source of Supply: A. H. Robbins Co., Richmond, Virginia.

Equanil
(Equanil Meprobamate)

Description: Each tablet contains 400 mgm of meprobamate, atactic agent; tranquilizer; muscle relaxant.

Action and Uses: As an anti-anxiety agent with muscle-relaxing properties. Action is confined to the central nervous system with no appreciable effect on activity of the heart, respiration or other autonomic functions. This drug is reliably effective, exerting a prolonged action with no undesirable side effects, in anxiety and tension states, in neurologic syndromes involving muscle spasm and in muscle spasm due to rheumatic conditions. It is also indicated in certain convulsive disorders.

Administration: Orally, one tablet three times daily is the usual dose. If needed an additional tablet is taken one hour before retiring. Because of low toxicity, wide adjustments in dosage are possible.

Supply: Tablet form 48 to the bottle, Wyeth, Philadelphia, Pa.

Vi-Cuta Skin Cream

Antipruritic; Anti-Bacterial.

Description: Contains pantothenyl alcohol 1 percent, pyridoxine Hcl 0.5 percent, hexachlorophene 0.5 percent and menthol 0.2 percent in a greaseless water-miscible, hypoallergenic cream buffered to normal skin pH 4.5.

Action and Uses: Provides effective antipruritic, antibacterial and healing action for use in treating common skin disorders, including overtreatment of dermatitis.

Administration: Topically.

Supply: Vi-Cuta Skin Cream in 1 oz. tubes. Columbus Pharmacal Co., Columbus 15, Ohio.

Nitrol Ointment

Peripheral vasodilator.

Description: This is an ointment containing glycerol trinitrate in a lanolin and white petrolatum base. The prompt peripheral vasodilation produced by nitroglycerin increases the blood flow, raises the skin temperature. Normal color returns to the area, ameliorates pain and burning sensation, obviates ulceration and favors healing of necrotic foci, restoring usefulness to the affected part. It has been useful in Raynaud's disease, frostbite, senile-gangrene, diabetic gangrene, chilblains, arteriosclerotic lesions of the leg, bed sores, thromboangiitis obliterans, cold extremities, Buerger's disease.

Administration: Topically, by rubbing the ointment into skin. Overdosage is indicated by a hypotensive headache. Dose should be adjusted to an amount which does not cause headache.

Supplied in 2 oz. tubes and one pound jars. Kremers-Urban.

Cordex Tablets

Description: Each tablet contains prednisolone 0.5 mg (metacortandralone) and 300 mg acetylsalicylic acid.

Indications: Treatment of rheumatoid arthritis, osteoarthritis, gouty arthritis, and bursitis.

Administration: Orally one or two tablets four times a day.

Supplied: Bottles of 100, 500, 1,000 and 5,000.

Source: The Upjohn Company, Kalamazoo, Michigan.

Cortef Intramuscular

Description: A suspension containing in each cc 50 mgm of hydrocortisone in sodium chloride injection with 4 mg of polysorbate 80 and 5 mg of carboxymethyl cellulose, with benzyl alcohol 0.9 percent as preservative.

Indications: Treatment of rheumatoid arthritis.

Administration: Intramuscularly. Upjohn Co. 5cc vials.

National Press Bldg., Washington, D. C.

COMMUNICATIONS TO THE PROFESSION

Dear Doctor:

Enclosed with this copy of the JOURNAL is the pamphlet, "Stepping Up To A Career," prepared by the Vocational Guidance Committee of the National Association of Chiropodists. This is one phase of an inclusive program on vocational guidance. The monograph, "Chiropody as a Career," is being mailed to each member of the National Vocational Guidance Association throughout the United States. Prints of the kodachrome film, "Chiropody as a Career," are being placed in a film library for distribution and showings to interested groups. An exhibit telling the story of Chiropody is being prepared to be displayed at the annual convention of the National Vocational Guidance Association being held in Washington, D. C., March 26-29, 1956.

To encourage the distribution of our new pamphlet, "Stepping Up To A Career," through our affiliated state societies, chiropody colleges and each individual member's office, the National Association is subsidizing such activity. For every 1000 pamphlets that the state society, college or member purchases, the National Association will contribute 500 copies gratis. These pamphlets cost the National Association $8.00 per thousand. The cost therefore for each 1000 copies ordered and the 500 copies that the National Association will contribute will be only $8.00. Postage and handling charges are also being assumed by the National Association. Please send your orders to the National office in Washington, D. C., at once.

L. B. Thompson, D.S.C.
Harry Horowitz, Pod.D.
Co-Chairmen, Vocational Guidance Committee

A.S.C.R. Plans Scientific Awards

The American Society of Chiropodical Roentgenology, knowing there is a void of scientific research within our profession, and believing that one of the better methods of expressing any science to the profession is via visual education, is contemplating an annual series of awards for outstanding individual exhibits relating directly or

indirectly with roentgen diagnosis. The competition would be open to all members of the N.A.C., with appropriate cash and plaque awards to be presented based upon the following: research, quality, appearance, appeal, originality, and effort. The theme of the exhibit could be basic research, case reports or review of accepted material.

Complete details will be made available at a later date providing there is sufficient expression of interest within the N.A.C. It is felt that an undertaking of this nature will stimulate research and self-expression within the chiropody profession. Briefly, herewith, then is the challenge. Who among us dare not accept? All interested members please communicate with the chairman of A.S.C.R. Project Committee.

James E. Bates, D.S.C.,
F.A.S.C.R.
5916 Greene Street
Philadelphia 44, Pa.

The Scientific Section of the N.A.C. is planning a Hall of Science for the annual meeting this year. Space is being allotted for technical and scientific exhibits by the individual chiropodist, affiliated groups, schools, and state societies. Members of the Technical Committee are asking full cooperation from all of the above individuals and groups. This notice is particularly directed to the chirop-

THE WM. J. STICKEL ANNUAL AWARDS FOR RESEARCH IN CHIROPODY FOR 1956

Sponsored by the

Journal of the National Association of Chiropodists

and The NAC Agency, Inc.

Twelfth Year of Awards

First Award — $400.00

Second Award — $250.00
Third Award — $100.00
Fourth Award — $50.00
Fifth Award — $50.00

Members who desire to submit papers should make application on a form which can be obtained from the Secretary.

Research papers on any subject in the field of Chiropody may be offered. The final date on which papers will be accepted is April 15, 1956.

odist who feels he has developed some particular technique worthy of exhibition. Any phase of chiropody illustrated by movies, stills, or models will be considered. All entries must be in the hands of the undersigned chairman by June 1, 1956, to be considered. Please send photographs of the exhibit along with the description of material used and size of the display. Movies and photographs must be mailed in suitable containers. Entries will be judged by the Scientific Committee and unused entries will be returned to their owners.

Dr. Ellsworth R. Johnson
Chairman, Technical Committee
Hall of Science Technical and Scientific Exhibits
314 May Building
Charleston, W. Va.

N.A.C. WOMEN'S AUXILIARY

Attention Ladies

Dear Non-Member:

Chiropody is a very young profession, from an organizational standpoint. In spite of its immaturity, tremendous strides have been made in the past few decades. As time goes on, chiropody is going to continue its progress. However, the rate of progress is proportionate to the effort put into it.

Because of our numercial weakness, chiropody needs the help and support of every person that is directly or indirectly receiving help from it.

Our appeal is directed to the wives of the N.A.C. chiropodists who have not affiliated themselves with the auxiliary of their locality. The purpose of the auxiliary is "to be of assistance socially and otherwise to the National Association and its affiliated state societies, and to promote and interest others in matters pertaining to the profession of chiropody-podiatry." In view of this justified reason for our existence, we deem it a privilege to belong and to lend our efforts to aid in the progress of our husbands' profession. We further believe that, directly and indirectly, we are bettering our personal position in life by belonging and helping to propagate the cause of chiropody.

The responsibility of doing this work is important and enjoyable in view of present results and the potential that can be achieved. If you feel that chiropody needs good, sincere people in its ranks, you can make yourself a part of the family by joining your state auxiliary, which automatically enrolls you in the national auxiliary. If you do not have a state auxiliary, send your name and address, together with two dollars to: Thelma Parham, Secretary-Treasurer, 1414 E. 17th Place, Tulsa, Okla. This will provide you with an individual membership. In this instance, we most cordially invite you to form an auxiliary society and affiliate with the national organization.

The dues are small considering the good it does. The frequent social side lends color and a time for less serious means of furthering cooperation and good felowship within a very wonderful profession.

Please consider this with more than casual thought and make a promise to contact your state auxiliary, the secretary-treasurer, or myself . . . NOW!

WE NEED YOU . . . LET'S GET TOGETHER.

Sincerely yours,

Vera Pearce, Vice President
N.A.C. Auxiliary
Membership Committee

4 St. Martha Ct.
Florissant, Mo.

EXECUTIVE COUNCIL TO MEET IN WASHINGTON

THE Executive Council of the N.A.C. will meet at the Woodner Hotel, Washington, D. C., on March 23, 24, 25, 1956. Their major concern will be to interview and consider applicants for the position of Business Administrator. A management consultant firm will have screened all the applicants, administered psychological and management tests, and certify from three to five candidates to the Executive Council for final selection.

CORRECTION NOTICE

IN the Amendment to the Constitution published in the December 1955 issue, Vol. 45, No. 12, Page 42, the following corrections are necessary:

Council on Education—Section 9. (a) The Council on Education shall be composed of eleven (11) voting members, as follows:

The House of Delegates of the National Association of Chiropodists shall elect a total of seven such voting members. . . .

ORGANIZATION NEWS

NEW MEXICO

THE New Mexico Association of Chiropodists held its annual meeting in Albuquerque on January 28-29, 1956. Dr. Charles Turchin of Washington, D. C., was the guest speaker and he gave a lecture on "Theory, Physiology and Treatment of Foot Imbalance."

The following officers were elected:

President,
Dr. M. M. Goodman
First Vice President,
Dr. Hazel Linard
Second Vice President,
Dr. M. Haas
Third Vice President,
Dr. P. Stevens
Secretary-Treasurer,
Dr. I. M. Gross

VIRGINIA

THE Virginia Association of Chiropodists will hold their semi-annual meeting on May 19-20, 1956, at the Hotel Jefferson in Richmond. The featured speaker will be Dr. Sidney Sivitz of Lewistown, Pa. Dr. Sivitz will lecture on the latest plastics, their indications and uses, and will demonstrate these in a practical workshop and with slides. A social event and business meeting will also be on the agenda. The complete program will be announced at a later date.

PENNSYLVANIA

Lehigh Valley Division

A REGULAR meeting of the Lehigh Valley Division of the Chiropody Society of Pennsylvania was held January 16, 1956, at the Lehigh Valley Club in Allentown. The following officers were elected: President, Dr. Richard Shaw; Vice President, Dr. Raymond Alexander; Secretary-Treasurer, Dr. Norman S. Reiter; Council Members, Drs. Roy Ronemus, H. Kares, W. R. Kehoe; Board of Governors, Dr. Miles Detweiler; Alternate, Dr. Joseph Dougherty.

Applications for membership were received from Drs. Walter Gislak and George Cihik.

A report was given on the progress of our State Bills 284 and 285 by Dr. Dougherty. No change has been made on the Blue Shield Bill.

A motion was passed to accept the invitation of the Medical Director of the Allentown State Hospital to conduct a survey of the Institution's 2,000 patients and report on the needs of these patients for foot care, and also recommend necessary clinical equipment and personnel required to complete this service. A sample form is to be made up for the survey.

He was instrumental in the passage of the first law governing the practice of chiropody in Washington and became secretary of the Board of Examiners, serving for twenty-four years without compensation. He is an Honorary Member of the Virginia and Maryland Societies, as well as the National Association of Chiropodists.

Dr. Rice wrote a chapter for the first Text Book of Chiropody, published in 1914 by the then New York School of Chiropody (now New York College of Podiatry). He lectured and demonstrated at this institution for many years and has written prolifically about the foot during World War II. He was civilian consultant for the Navy Department on the designing of the shoe for the Navy personnel.

IDAHO

THE Boise chiropodists consisting of Drs. Partridge, Lonsdale, Kingland, and Franden have started a program of clinical service at the Ada County Hospital of the Children's Home Finding and Aid Society.

The Idaho Association of Chiropodists is holding its annual meeting at the Boise Hotel, Boise, Idaho, May 18-20, 1956. Drs. Douglas Mowbray and Stewart Reed will be guest speakers on May 19th and 20th.

The Idaho Junior Chamber of Commerce, through Dr. William Wattling of Lewiston, chairman of the Washington Jaycee's health program, has put into operation a free children's foot examination clinic. This project is sponsored by the Jaycees with the cooperation of the local chiropodist in each city.

THE HOUSE OF COMFORT

known for

Their outstanding, skilled craftsmanship in the appliance of old-fashion and modern hand-made foot appliances for any kinds of deformity as well as Balance Inlays, Levy and Sansone Molds, Celastic, and arches of oak sole leather with blue tempered steel springs; also flexible type of supports of cork and rubber.

We also construct any type of stainless steel plates.

The priceless knowledge and experience which we learned and inherited from our fathers enable us to be very proud of our scores of years in orthopaedic work.

Every appliance constructed in our laboratory is hand made. We DO NOT HAVE ANY STOCK APPLIANCES OF ANY KIND.

It is our proud privilege to serve you and the profession in your every need and we look forward to hearing from you in the near future. Write for our literature.

LEVY & RAPPEL, INC. *The home of individual orthopaedic appliances*

384 COLUMBUS AVENUE **NEW YORK 24, N. Y.**

WASHINGTON

THE Washington State Chiropody Association proudly hosts the Regional Meeting which will be held on April 27-29, 1956, at the Benjamin Franklin Hotel in Seattle, Wash. The speakers will be Drs. E. C. Meldman and H. T. Frohlich. These two men are bringing some new practice techniques to the Northwest which will benefit the profession. Plan now to attend. A complete program will follow in future issues.

DISTRICT OF COLUMBIA

IN recognition of his more than sixty years of practice, his high ethical, personal and professional standards, his deep interest in our colleges and students and his lifelong devotion to the advancement of podiatry, friends and colleagues of the Podiatry Society of the District of Columbia presented Eugene C. Rice, M.D., with a plaque on February 15th.

Dr. Rice began his chiropody career as a student under Dr. Nehemiah Kenison of Boston, and realizing that a medical background was essential, he took a full four-year course at Columbia (now George Washington) College of Medicine. He was one of the organizers of the National Association of Chiropodists, serving on many of its committees, and organized the Podiatry Society of the District of Columbia and became its first president.

Mr. Snyder, public relations representative of the Pennsylvania Bell Telephone Company, presented a film entitled, "Thanks for Listening." He explained the proper use of the office telephone.

The scientific program has been made up for the year by Drs. Roland Brior and Joseph Dougherty.

The next meeting of the Lehigh Valley Division was held February 20, 1956, at the Lehigh Valley Club and the speaker was Mr. James C. Laske, who is an attorney before the U. S. Supreme Court. His subject was chiropodical and medical malpractice.

Northwestern Division

The Northwestern Division of the Chiropody Society of Pennsylvania held its regular meeting January 15, 1956, at the Exchange Hotel in Franklin. The following officers were elected for the ensuing year: President, Dr. Roy Yorns; Vice President, Dr. Leonard Pleban; Secretary-Treasurer, Dr. Leo J. Nelson.

Dr. Rossi led a very interesting discussion on the treatment and results of the various treatments for "Heel Spur."

Western Division

The Western Division of the Chiropody Society of Pennsylvania held a meeting on Thursday, February 9, 1956, at the Mellon Institute in Pittsburgh.

Dr. Leslie Morris, staff member of the Montefiore Hospital and recently appointed consultant to the Pittsburgh Diagnostic Clinics for Peripheral Vascular Diseases, was the scientific speaker of the evening. His topic of discussion was "Peripheral Vascular Diseases of the Extremities."

Philadelphia Chiropody Society

The regular monthly meeting of the Philadelphia Chiropody Society was held Tuesday, January 17, 1956, at the Philadelphia County Medical Society Building. Dr. Louis M. Newman, President of the Society, presided.

Joseph M. Horwitz, D.S.C., was the guest lecturer of the evening. His subject was, "A New Dynamic Treatment for Neuro-Muscular Re-education."

The meeting was attended by many physicians from the area as

the result of public announcement in the major newspapers.

Dr. Horwitz' lecture and demonstration concerned itself with biodynamic electro-diagnosis and indications for suitable therapeutic measures. As the meeting was covered by the press, a considerable amount of linage appeared in the local newspapers.

A photostatic copy of the newspaper releases will be sent by Dr. Leon L. Brandolf, Secretary, Philadelphia Chiropody Society, 217 E. Baltimore Avenue, Clifton Heights, Pa., to those requesting it.

WEST VIRGINIA

A MEETING of the Northern Zone of the Chiropody Society of West Virginia was held January 11, 1956, at the Daniel Boone Hotel in Charleston. Dr. John J. Bates, president of the organization, presided. A scientific session was held following the business meeting.

Mr. Dave Fenton of the Jerry Miller I.D. Shoes, Inc., presented a program, which consisted of the following concerning the shoes: function, casting technique, fees, office use, advantages, disadvantages, demonstration in casting technique, where indicated, and therapeutic value.

Many members from various parts of the state attended the meeting.

ILLINOIS

DR. MAURICE R. UDELL was elected scientific chairman of Zone One at a meeting held in the office of Dr. E. Peterson on January 11, 1956, in Chicago.

Zone One is comprised of 96 members and all are invited to attend the meetings which are held every other month.

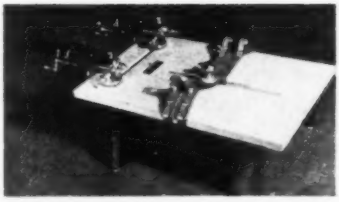
The following are the officers: Dr. John Quinn, President; Dr. John L. Hancock, Vice President; Dr. F. A. Hines, Secretary.

This notice is being published to help stimulate the interests of the members and to get better attendance at the meetings. A series of lectures on the management and control of orthopedic foot problems will be given by Dr. G. R. Gabriel.

The next meeting will be held March 14, 1956, at the office of Dr. E. Peterson, 1005 W. Belmont, Chicago, Ill.

IOWA STATE CHIROPODY BOARD EXAMINATIONS

THE Iowa State Chiropody Board wishes to announce that the next Iowa State Board Chiropody examinations will be held at the State Office Building in Des Moines, Iowa, on June 4, 5, and 6, 1956.



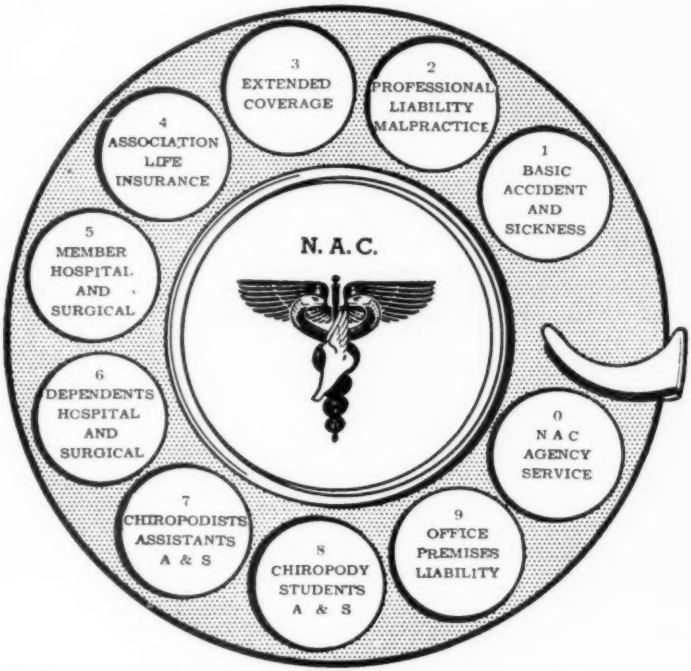
ORTHO-TRAC TRACTION THERAPY

Most Advanced—at its Best

See the April, 1954 issue of the Journal for 14 page illustrated article and contact

SURGICAL SUPPLY SERVICE, 825 Walnut St., Phila. 7, Pa.

SERVING CHIROPODY EXCLUSIVELY SINCE 1935


N. A. C.
1 BASIC ACCIDENT AND SICKNESS
2 PROFESSIONAL LIABILITY MALPRACTICE
3 EXTENDED COVERAGE
4 ASSOCIATION LIFE INSURANCE
5 MEMBER HOSPITAL AND SURGICAL
6 DEPENDENTS HOSPITAL AND SURGICAL
7 CHIROPODISTS ASSISTANTS A & S
8 CHIROPODY STUDENTS A & S
9 OFFICE PREMISES LIABILITY
0 N A C AGENCY SERVICE

No Wrong Numbers Here

THE NATIONAL ASSOCIATION OF CHIROPODISTS
INSURANCE PLANS

Administered By

THE NAC AGENCY INC.

35 Market Street Poughkeepsie, N.Y.

Please send full particulars for Plans—checked.

(1) (2) (3) (4) (5) (6) (7) (8) (9)

Name .....

Address .....

City ..... State .....

MOOD ELEVATORS

Contributions to this column are more than welcome. In fact it depends upon them.

A.O.P.

Dr. B. came out of his treatment room and walked dizzily into the private office which he shared with Dr. C., "Boy, have I had it!" he griped.

"What's the matter?" asked Dr. C.

"Old Mrs. X.," fumed Dr. B. "For half an hour I had to listen to an *organ* recital."

———

Seeing that his patient was a new one the doctor spoke with a little more than his usual cheeriness. "Well, sir, what brings you to the foot specialist?"

"That corn," replied the man, pointing to his little toe. "I'd like to have it chiropodated."

———

The Southern Railway has a little magazine which contains a clever squib now and then like this:

"Most of the footprints in the sands of time were left there by work shoes."

———

The porter was pushing his merchandise cart through the crowded aisles of the department store but making slow headway. "Gangway! Gangway please!" But no one paid any attention. He tried again. No better. Then,

"Coming through! Watch your nylons," he roared. "After that a wide open thoroughfare appeared.

From the Wonder Flame, Washington Gas Light's House Organ

FOOT BALANCE INLAYS

are only completely

successful

when each case

is individually studied, diagnosed

and an inlay made to fit its

special requirements

The laboratory of

CARL G. BERGMANN, D.S.C.

5406 BROADWAY **CHICAGO 40, ILL.**

originator of foot balance inlays is directed
in all its endeavors to accomplish this result

DEATHS REPORTED

Reuben Friedman, M.D.
Philadelphia, Pa.

DR. REUBEN FRIEDMAN, Professor of Dermatology at the School of Chiropody, Temple University, passed away on February 4, 1956. He graduated from the Medical School of Temple University in 1916 and pursued graduate courses at the University of Vienna.

Dr. Friedman was vice chairman of the medical board at the Skin and Cancer Hospital. He was the author of "Biology of the Acarus Scabiei," "Story of Scabies," and "History of Dermatology in Philadelphia." He was a past president of the Philadelphia Dermatological Society, Fellow of the College of Physicians of Philadelphia and an honorary member of the Society of Dermatology of Italy, Society of Dermatology of Cuba and the National Association of Chiropodists.

Dr. Michael H. Arbogast
Buffalo, N. Y.

DR. MICHAEL H. ARBOGAST passed away at the age of 79 on January 18, 1956, at Buffalo, N. Y. He was an untiring worker for the profession and one of its outsanding members.

Dr. Arbogast was one of the first to use the term Podiatry, exclusively. The first out-patient clinic in the Buffalo General Hospital was created by Dr. Arbogast. He

(Continued on Page 202)

ACCREDITED CHIROPODY COLLEGES

California College of Chiropody
1770 Eddy Street
San Francisco, Calif.

Chicago College of Chiropody
1422 W. Monroe Street
Chicago, Ill.

Illinois College of Chiropody and Foot Surgery
1327 North Clark Street
Chicago, Ill.

New York College of Podiatry
53 East 124th Street
New York, N. Y.

Ohio College of Chiropody
2057 Cornell Road
Cleveland, Ohio

Temple University, School of Chiropody
1810 Spring Garden Street
Philadelphia, Pa.

DEATHS REPORTED

(Continued from Page 201)

served in every office of the Erie County Podiatry Society, which he helped found, later becoming president of the state society and delegate to the N.A.C. convention serving on many national committees. He was voted Life Membership by the Board of Governors of the Podiatry Society of the State of New York.

Dr. Arbogast is survived by his brother, Dr. Joseph, and his wife and daughter.

FAY METATARSAL RUBBER BARS

Easy to attach to sole of shoe. Exercises feet. Five sizes. Rubber gives comfort. Doctor's Introductory Package: 15 pair assorted styles and positioning chart. Order of your JOBBER.

These Jobbers Will Supply You

C. H. Hittenberger, San Francisco
Chicago Medical Equipment Co., Chicago
Chiropody Supply Headquarters, Chicago
Chiropody Supply Headquarters, New York
Deer Products Co., Pittsburgh, Penn.
General Chiropody Supply, Brooklyn, N. Y.
Julius Rothschild, Long Island, New York
Katzenstein Professional Supply Corp., N. Y.
Midwest Chiropody Supply, Ottumwa, Iowa
National Medical Supply Co., Chicago
Surgical Supply Service, Philadelphia

CARL F. FAY ESTATE
3025 Farnam St., Davenport, Iowa

Your Patients Can Now Enjoy All of the Comforts of

"MOLDED SHOES"

Without Conspicuousness

No casts **No waiting**

Contur-a-Mold Provides All of the Advantages of Any "MOLDED SHOE" Without the Objectionable Features.

FULL FOOT MOLDS can be processed in Your Patients Shoes with only 15 minutes of your time.

Give Your Patients the Comfort They Want in STYLE
Descriptive Brochure on Request—write:

PROFESSIONAL PRODUCTS CO.
31 Houston Ave., Muskegon, Mich.

CONVENTION DATES

1956

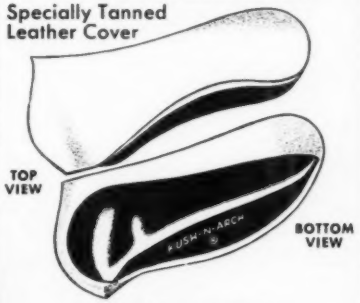
NATIONAL ASSOCIATION OF CHIROPODISTS
Chicago, Ill., August 1-9, 1956
Drake Hotel

REGION FIVE
Chicago, Ill.
March 16-18, 1956
Morrison Hotel

(Continued on Page 204)

Printing and Records
HISTACOUNT®
PROFESSIONAL PRINTING COMPANY, INC.
NEW HYDE PARK, N. Y.

KUSH-N-ARCH®
MEDIAL ARCH ***Insert***
THE PERFECT INSERT FOR THE CHIROPODIST
Specially Tanned Leather Cover



Adjustable to all sizes by sanding
Prices on Request. . . . Write to:
Sales Research Agency
OCONOMOWOC, WISCONSIN

America's Most Fabulous City

VISIT NEW ORLEANS

and the Southwestern Chiropody Congress

Program feature: "Complete Foot Rehabilitation"

with: Dr. Raymond K. Locke

May 6, 7, 8, 1956 **Jung Hotel**

Your Feet Are Your Foundation

FOREDOM CHIROPODY DRILLS

PIONEERS . . . AND . . . AFTER 33 YEARS STILL THE LEADERS!

The ONLY complete line. Cable and All-cord models — floor, wall and cabinet types — combination drill-vibrators — percussion vibrator attachments for cable drills.

Send for COMPLETE Catalog No. C11C

When you buy FOREDOM you get the BEST at a price which offers a challenge to imitators.

AT YOUR DEALER'S

Foredom Electric Company
Dept. C11C, 27 Park Place
New York 7, N. Y.

CONVENTION DATES

(Continued from Page 203)

REGION SIX
Des Moines, Iowa
April 6-8, 1956
Hotel Savery

REGION THREE
Atlantic City, N. J.
April 12-15, 1956
The Ambassador

REGION SEVEN
Seattle, Wash.
April 27-29, 1956
Benjamin Franklin Hotel

WYOMING ASSOCIATION OF CHIROPODISTS
Casper, Wyo.
May 5-6, 1956
Gladstone Hotel

SOUTHWESTERN CHIROPODY CONGRESS
New Orleans, La.
May 6-7, 1956
Jung Hotel

REGION FOUR
Columbus, Ohio
May 17-19, 1956
Deshler-Hilton Hotel

WESTERN CHIROPODY CONGRESS AND 37TH ANNUAL CONVENTION OF THE CALIFORNIA ASSOCIATION OF CHIROPODISTS
Los Angeles, Calif.
May 28-29, 1956
Ambassador Hotel

REGION ONE
Swampscott, Mass.
October 12-14, 1956
New Ocean House

IDAHO ASSOCIATION OF CHIROPODISTS
Boise, Idaho
May 18-20, 1956
Boise Hotel

Chiropody . . .

X-RAY

SUPPLIES

EQUIPMENT

INSTRUMENTS

Distributors

Ritter Chiropody Equipment

•

A Service Institution

CHICAGO MEDICAL EQUIPMENT COMPANY

17 NORTH WABASH AVENUE
CHICAGO, ILLINOIS

Please do not ask for the names of classified advertisers in the JOURNAL who use box numbers. We accept such advertisements with the understanding that this information will not be released. Address replies or inquiries to the box number shown in the advertisement. They are promptly forwarded to the advertiser.

CLASSIFIED ADVERTISEMENTS

Advertisements not exceeding 30 words cost $3.00. Additional words 10 cents each.

Commercial classified advertisements—minimum 30 words $10.00; 30 cents per additional word.

All classified ads payable in advance. Remittance must accompany order for insertion.

PRACTICE AND HOUSE FOR SALE: Chiropodist with New York license for established practice, sufficient equipment. House well located. Priced right for sale. Write 300, c/o National Association of Chiropodists, 3301 16th St., N.W., Washington 10, D. C.

WANTED: Recent graduate, California license, desires associateship with progressive chiropodist in Southern California. Purchase of practice may be considered. Will also take offices during vacation or illness. William O. Nankee, D.S.C., 259 Euclid Ave., Pasadena 1, Calif.

WANTED: Any visual aids, movies, slides or photos that are available for loan or rent, for use by the Public Relations Committee of the Illinois Chiropody Society. Please contact Dr. M. L. Golde, 2104 Broadway, Rockford, Ill.

WANTED: Used chiropody chair, stool, cabinet drill, whirlpool, sterilizer, etc. Must be in excellent condition. Details to 316, c/o National Association of Chiropodists, 3301 16th St., N.W., Washington, D. C.

WANTED: Capable podiatrist-chiropodist in a medical building, Central Nassau County and in a community of 20,000 population. For particulars write Wm. H. Cordes, 73 Nassau Blvd., Garden City, N. Y.

WANTED: Associateship by chiropodist licensed in Iowa, Wisconsin and Minnesota. Two and a half years experience. Equipment available if necessary. Write 302, c/o National Association of Chiropodists, 3301 16th St., N.W., Washington 10, D.C.

WANTED: Partnership or purchase of active practice; associateship leading to partnership or purchase of practice in New York State or Connecticut. Excellent background and experience. Leaving Army in August. Write 304, c/o National Association of Chiropodists, 3301 16th St., N.W., Washington 10, D. C.

FOR SALE: Well-established chiropody practice; South Dakota City of 65,000 population; ten years same location. Unusual opportunity for modest asking price considering income return and possibilities. Leaving state. Write 306, c/o National Association of Chiropodists, 3301 16th St., N.W., Washington 10, D. C.

FOR SALE: Northeastern Pennsylvania. Modern, well-rounded practice, good fees, centrally located. Quick sale price including equipment, less than year's gross. Reason—other interests. Write 308, c/o National Association of Chiropodists, 3301 16th St., N.W., Washington 10, D. C.

WANTED: Recent graduate desires associateship in Eastern Pennsylvania or New Jersey, with intentions of buying practice. Will furnish own equipment if necessary. Write 310, c/o National Association of Chiropodists, 3301 16th St., N.W., Washington 10, D. C.

Skin Adherent No. 2

Does Not Irritate the skin

Sold by all dealers

SEND FOR SAMPLE

THE MOWBRAY CO., WAVERLY, IOWA

RECENT GRADUATE: Excellent opportunity to take up where I leave off. Completely equipped, $1,200.00 and you earn it back immediately. No competition. 17 miles west of Philadelphia. Write 312, c/o National Association of Chiropodists, 3301 16th St., N.W., Washington 10, D. C.

FOR SALE: Physiotherapy table, with adjustable back and leg rests; practically new, includes two drawers and storage space; metal, ivory color with black leather upholstery, $100.00. Also 1,000 watt three-speed infra-red lamp, like new, with casters $30.00. Write 314, c/c National Association of Chiropodists, 3301 16th St., N.W., Washington, D. C.

Everyday interested chiropodists are requesting sample copies of —

FOOT FACTS

Publications

P. O. BOX 935

MIAMI BEACH 39, FLORIDA

PREPARATIONS FOR THE CHIROPODIST

Soapless Sudsing ***Antibacterial Detergent***

pHisoHex®

Cumulative bacteriostatic action in

Infections
(prophylactic-therapeutic)

Bromidrosis

Vascular disease of the extremities

pHisoderm® *(OILY TYPE)*

for dry feet and legs

Dependable Antiseptic for Office Use

ZEPHIRAN® CHLORIDE

(brand of benzalkonium chloride—refined)

Powerful
Economical
Versatile

Pioneer Local Anesthetic

NOVOCAIN®

(brand of procaine hydrochloride)

Quick onset
Dependable action
Excellent tolerance

WINTHROP LABORATORIES New York 18, N. Y., Windsor, Ont.

Write for informative illustrated booklet

Skin prepared with Mennen Skin Magic displays effective water-repellency.

NEW COSMETIC LOTION WITH SILICONES

. . . AN AID IN CHIROPODY

A REPORT from a leading bio-chemist will interest chiropodists treating dermatophytosis and many other conditions. Tests on human skin, employing Mennen Skin Magic with silicones, demonstrate its water-repellent action after multiple washings with soap and water; after washing with a commercial detergent, and an alkaline laboratory cleanser.

In addition to silicones, the Mennen Skin Magic formula contains cholesterol and related sterols, methylbenzethonium chloride. The latter provides a mild antiseptic action helpful in daily foot prophylaxis. Skin Magic also serves as an effective deodorant; has no medicinal odor; leaves a pleasant "cosmetic" fragrance. A rich but non-greasy emollient, it quickly softens rough heels and calloused areas; aids in healing scaling and skin fissures between toes; and is excellent for general foot massage.

For a professional sample, address The Medical Director, The Mennen Company, Morristown, N.J.